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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 4 3 1 5 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Catherine Viola AKERS			2a. DATE OF DEATH MONTH DAY YEAR May 15 1983		2b. HOUR 12:35 P.M.
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 6/28/85	6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.		# UNDER 1 YEAR # UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MO.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.		
10. CITY OR TOWN OF DEATH WILLIAMS PORT	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WILLIAMS PORT NURSE HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MO.			13b. COUNTY WASHINGTON	13c. CITY OR TOWN WILLIAMS PORT	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST TOBIAS AKERS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IOWA MERRIAMAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214145818	17. INFORMANT ADDRESS MAX SCHMELZ 9900 BIRD RIVER RD		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circuimatomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Organic Brain Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1991</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1991</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>August 31</u> 19 <u>76</u> , to <u>May</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>May 16</u> 19 <u>83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23a. SIGNATURE John R. Melnick		DEGREE MD		22c. DATE SIGNED	
23d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Melnick		22e. ADDRESS 16220 Frederick Rd., Gaithersburg, MD 20760			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 5/26/83		23c. NAME OF CEMETERY OR CREMATORY SECURITY PROCESS	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.		23e. DATE REC'D. BY REGISTRAR MAY 31 1983			
24. FUNERAL DIRECTOR NAME J.B. CONNELLY		ADDRESS 300 MACE		25. REGISTRAR'S SIGNATURE Joan J. Connelly	

10

Handwritten notes and diagrams on lined paper, including a large circular diagram with internal lines and a small rectangular diagram.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 business days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 3 1 4 3 1 6 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR	
Sabina		K. Baker		5 29 83 6:38 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
F		W		2 10 88	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Md.		U.S.A.		95 YRS.	
8. CITY OR TOWN OF DEATH		9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Hagerstown		Washington County MD.		Housewife	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Washington Cty. Hosp. & Inst.		Housewife		Own Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Washington		Hagerstown	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
Jacob M. Snively		Emma K. Thomas		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)	
212-38-9762		Mrs. Ecile Shaffer, Hagerstown, Md. 21740		4360 Cardio respiratory arrest Renal Failure Left CVA	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				10 days	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		19			
21a. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/28 19 83, and that (I) (we) lost saw the deceased alive on 5/28 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE R. Lawrence Kugler		22c. DATE SIGNED 5/27/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE SIGNED	
R. Lawrence Kugler		Geeting Lane, Keedysville, Md.		5/27/83	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		6-I-83		Fairview Cemetery	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
John H. Bast, Jr.		Boonsboro, Md. 21713		JUN 01 1983	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	
				John J. Casper	



TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
DATE: [illegible]  
[illegible text follows]

[illegible text]

[illegible text]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 14317			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 5-15-83			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Olive Ray Baldwin				2b. HOUR 8:57 M			
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 8-8-1894		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fahrney-Keedy Memorial Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Nursing	
13a. STATE Md. 21713		13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Gabriel Luther Conrad		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Anne Kanavel		13e. STREET ADDRESS Route 2 P.O. Box 78 21713			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW1 579-20-3026		17. INFORMANT ADDRESS Victor P. Conrad Route 8 P.O. Box 236 Hagerstown, Md. 21740			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> <u>4275</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Respiratory Distress</u> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>None</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 14</u> 19 <u>83</u> <u>July</u> 19 <u>82</u> , to <u>May 15</u> 19 <u>83</u> , that <u>X</u> (we) last saw the deceased alive on <u>May 14</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>ABDUL WATREED MD</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/15</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ABDUL WATREED MD</u>		22e. ADDRESS <u>1600 OAK HILL AVE. HAZ. MD 21740</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>5/20/83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Grove Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Salem, Mass.</u>	
24 FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> NAME <u>5130 Wisc. Ave. N.W. Wash., D.C. 20016</u>				25a. DATE REC'D. BY REGISTRAR <u>MAY 20 1983</u>		25b. REGISTRAR'S SIGNATURE <u>Sam E. Conrad</u>	

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U.S.A.

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Mr. S. J. ...

Washington, D.C. 20540

Victor J. ...

Will

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May 12

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July

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May 14



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Harmony Grove Cam.

5/20/83

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Joseph ...  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8314318
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>LEONIA HILDA BARNES</b> <i>Leonia H. Barnes</i>					2a. DATE OF DEATH 5/10/1983 3-10-83			2b. HOUR 9:07 P.M.		
3. SEX <b>Female</b>		4. RACE <b>White</b> <i>Cauc</i>		5. DATE OF BIRTH MONTH DAY YEAR 8-7-05		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Wash.</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. # 5, Box 398</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH W. BARBEE</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELIZABETH "MONROE"</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>NONE</b>		17. INFORMANT ADDRESS <b>Barbara Kline/101 Windsor Dr. Hag.</b>						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Probable pulmonary embolus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Diabetes mellitus</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Hypertension</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <b>4/15</b> , 19 <b>77</b> , to <b>5/10</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>4/18</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.										
22b. SIGNATURE <i>George C. Newman, II</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/16/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE C. NEWMAN, II, PH.D., M.D.</b>					22e. ADDRESS <b>1825 HOWELL ROAD, HAGERSTOWN, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5/13/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash. Md.</b>				
24. FUNERAL DIRECTOR (NAME) <b>Rest Haven Funeral Chapel, Inc.</b>					25. DATED BY REGISTRAR? REGISTRAR'S SIGNATURE <b>MAY 19 1983 John J. Conner</b>					
26. ADDRESS <b>1601 Pennsylvania Ave. Hagerstown, Md.</b>										

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may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 4 3 1 9  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
Charles W. Bartlett		5 5 83		131 P. M.	
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Male	Caucasian	MONTH DAY YEAR	64	MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 24 HRS	
Hagerstown, USA		Washington Co.		MONTHS DAYS HOURS MIN.	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Hagerstown, Md.		Washington County Hospital		GUARD	
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		15. INSIDE CITY LIMITS?		16. STREET ADDRESS	
13a. STATE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21740	
Md.		13b. COUNTY		824 Lurvale St.	
Washington		13c. CITY OR TOWN			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Lewis Bartlett		Agnes Jorden			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		17b. SOCIAL SECURITY NO.		17c. INFORMATION	
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/>		219-01-9360		MARION BARTLETT / SAME AS 13C	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarct</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4100</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>40 mins.</u>					
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-5-83</u> , 19 <u>83</u> , to <u>5-5</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>5-5-83</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
M.J. Cannon		M.D.		5-7-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
M. J. Cannon M.D.		King & Antietam Sts. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		5/7/83		REST HAVEN Cem.	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25. DATE RECEIVED BY REGISTRAR	
REST HAVEN FUNERAL CHAPEL, INC.		1601 PENNSYLVANIA AVE. HAGERSTOWN, MD.		MAY 12 1983	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 4 3 2 0 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Beatrice E. Bonebrake</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5-7-83</b>			2b. HOUR <b>8:45</b> M					
3. SEX <b>F</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 3, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.	
9. BIRTHPLACE (STATE OR FOREIGN) <b>MD</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington Co., MD.</b>					
12. CITY OR TOWN OF DEATH <b>Hagerstown</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wash. Co. Hospital</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		15. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Wash.</b> 13c. CITY OR TOWN <b>Hagerstown</b>		17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18. STREET ADDRESS <b>1303 Old Colony Lane</b>							
19. FATHER'S NAME FIRST MIDDLE LAST <b>Stanley W. Hattle</b>				20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eleanor - Barnhart</b>							
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)				22. SOCIAL SECURITY NO. <b>165-10-9372</b>		23. INFORMANT ADDRESS <b>Robert G. Bonebrake - Hagerstown, Md.</b>					
24. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>0399 cardiac arrest</b> IMMEDIATE CAUSE (a) <b>cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Septicemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
24. DATE OF OPERATION			25. CONDITION FOR WHICH OPERATION WAS PERFORMED				26. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		33. LOCATION STREET CITY OR TOWN COUNTY STATE						
34. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
35. SIGNATURE <b>A. Wheel</b>				DEGREE <b>md</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		36. DATE SIGNED	
37. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABDUL WAHEED md</b>				38. ADDRESS <b>1600 Oak Hill Ave. Hgt. n.w. 2140</b>							
39. BURIAL, CREMATION, REMOVAL <b>Burial</b>			40. DATE <b>May 11, 1983</b>		41. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cem.</b>		42. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Md.</b>				
43. FUNERAL DIRECTOR <b>Marvin Miller - Greenleaf, PE</b>				44. DATE REC'D. BY REGISTRAR <b>MAY 11 1983</b>							
				45. REGISTRAR'S SIGNATURE <b>John J. Gamm</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 4 3 2 1 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <u>Gentruide E. Bowman</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>5 31 83</u>				2b. HOUR <u>9.30 4 M</u>
3. SEX <u>Female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>9 27 1898</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>84</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington County</u> MD.				
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington County Hosp</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>		
13a. STATE <u>Md</u>				13b. COUNTY <u>Wash</u>	13c. CITY OR TOWN <u>Hagerstown</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <u>Walnut Towers</u> 21740	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Isaac Long</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Estella Hagerman</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>214-09-7520</u>		17. INFORMANT ADDRESS <u>Mr. Alaric Bowman 313 Dinkel Ave. Bridgewater, Va. 22812</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4140 Arterio-sclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Chronic obstructive pulmonary disease</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>5/20</u> , 19 <u>83</u> , to <u>5/31</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>5/30</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>P Hoachlander</u> M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/31/83</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>E Hoachlander</u>				22e. ADDRESS <u>Hagerstown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		23b. DATE <u>5/31/83</u>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <u>Anatomy Board</u>				ADDRESS <u>Balto., Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 3 1983</u>		
				25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.



## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 3 1 4 3 2 2 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Grace Pearl BOWMAN						2a. DATE OF DEATH MONTH DAY YEAR May 7, 1983		2b. HOUR M	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR August 7, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) secretary		12b. KIND OF BUSINESS OR INDUSTRY Salvation Army	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown	
14. FATHER'S NAME FIRST MIDDLE LAST David G. Bowman						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora G. Toms			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-8737		17. INFORMANT ADDRESS Mrs. Pauline Mace, Hagerstown, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bilateral pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4860</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Abdul Waheed</u>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Abdul Waheed, M.D.				22e. ADDRESS 1600 Oak Hill Ave, Hagerstown, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE May 10, 1983		23c. NAME OF CEMETERY OR CREMATORY Welty Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Greensburg, Wash., Maryland			
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME 415 East Wilson Blvd., Hagerstown, Maryland 21740						25a. DATE REC'D. BY REGISTRAR MAY 11 1983			
REGISTRAR'S SIGNATURE <u>John J. Connel</u>									

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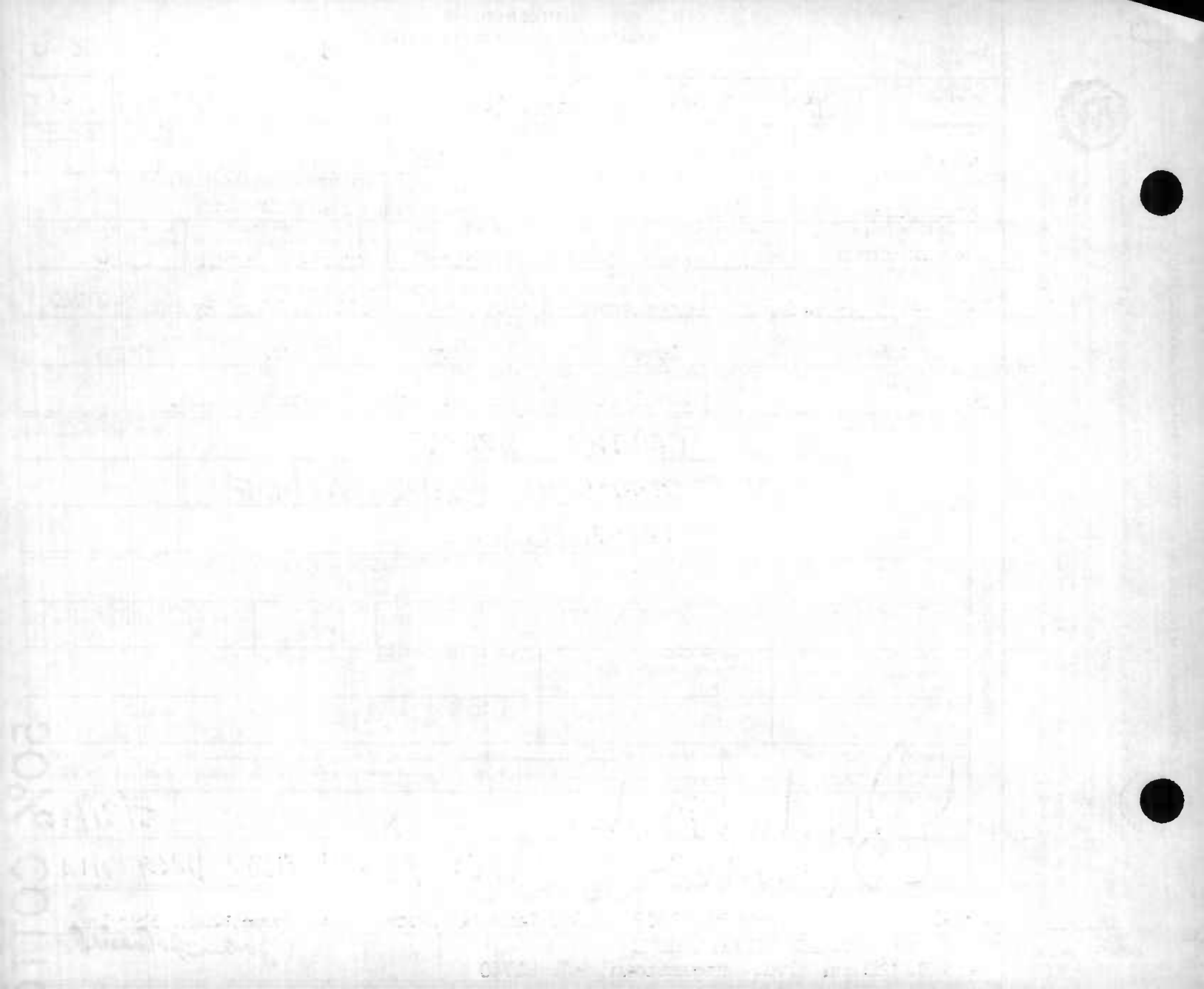
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 4 3 2 3 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <u>JOHN</u> <u>Lewis</u> <u>Boyer</u>					2a. DATE OF DEATH MONTH <u>5</u> DAY <u>27</u> YEAR <u>1983</u>			2b. HOUR <u>1:21 P</u> M			
3. SEX <u>male</u>		4. RACE <u>white</u>		5. DATE OF BIRTH MONTH <u>April</u> DAY <u>16</u> YEAR <u>1906</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>77</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS HOURS <u></u> MIN. <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington</u> MD.					
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington County Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>street dept.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>City</u>			
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Washington</u>		13c. CITY OR TOWN <u>Hagerstown</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>510 Guilford Avenue</u> <u>21740</u>			
14. FATHER'S NAME FIRST <u>Charles</u> MIDDLE <u></u> LAST <u>Boyer</u>					15. MOTHER'S MAIDEN NAME FIRST <u>Mary</u> MIDDLE <u>C.</u> LAST <u>Plume</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>180-03-6422</u>		17. INFORMANT ADDRESS <u>Alta M. Boyer, Hagerstown, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>4029</u> IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>CD Wooster</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <u>5/31/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CD Wooster</u>					22e. ADDRESS <u>1825 Howell Road Hager Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>			23b. DATE <u>May 31, 1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Mem. Park</u>			23d. LOCATION CITY OR TOWN <u>Hagerstown, Wash., Maryland</u> COUNTY <u></u> STATE <u></u>			
24. FUNERAL DIRECTOR NAME <u>MINNICH FUNERAL HOME</u> ADDRESS <u>415 E. Wilson Blvd., Hagerstown, Md. 21740</u>					25a. DATE REC'D. BY REGISTRAR <u>5/31/83</u> REGISTRAR'S SIGNATURE <u>John J. Graw</u>						

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 4 3 2 4  
REG. NO.

FOR  
1 - STATE  
REGISTRAR

James Raymer

Brewer

1. DECEASED NAME (TYPE OR PRINT) JAMES RAYMER BREWER			2a. DATE OF DEATH MONTH DAY YEAR MAY 25, 1983			2b. HOUR 6:30 A.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 17, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co., MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Signal maintainer		12b. KIND OF BUSINESS OR INDUSTRY Wm. D. P.R.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.					13b. COUNTY WASH.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James S. Brewer					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan F. Nicarry					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE YEAR OR DATES) Yes 1932-1933			16b. SOCIAL SECURITY NO. 105-10-7715			17. INFORMANT ADDRESS Kw. Longmeadow Rd. Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute myocardial infarction 1 day DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease 2-3 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerosis C.U.D. years										
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21a. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21c. LOCATION STREET CITY/TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 2 May 1970 to date that (I) (we) last saw the deceased alive on 23 May 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (old) (did not) view the body after death.										
23a. SIGNATURE B. D. Binford						23b. ADDRESS Hagerstown Md		23c. DATE SIGNED 25 May 83		
24. PHYSICIAN'S NAME (TYPE OR PRINT) Binford						24b. ADDRESS				
25a. FUNERAL CREMATION, REMOVAL Burial			25b. DATE MAY 25, 1983			25c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Ch. Cem.			25d. LOCATION City or Town County Farmview-Wash. Co., Md.	
26. FUNERAL DIRECTOR MARVIN MILLER - GREENCASTLE PA.						27. DATE REC'D. BY REGISTRAR JUN 3 1983				
28. REGISTRAR'S SIGNATURE John J. Cawley										

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be directed for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Printed and Published by  
JUN 3 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #15 Film G580 6/9/83 rc

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 14325  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT Leo BRUBAKER</b>			2a. DATE OF DEATH MONTH <b>5</b> DAY <b>23</b> YEAR <b>83</b>			2b. HOUR <b>1:20</b> P.M.				
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH <b>Nov.</b> DAY <b>28</b> YEAR <b>1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bio-Lab Technician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NIH</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>743 S. Potomac St. 21740</b>	
14. FATHER'S NAME FIRST <b>Cecil W.</b> MIDDLE <b>Brubaker</b> LAST <b></b>					15. MOTHER'S MAIDEN NAME FIRST <b>Ada Mae</b> MIDDLE <b>Brubaker</b> LAST <b>Brubaker</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>U.S. Army</b>			16b. SOCIAL SECURITY NO. <b>215-26-1431</b>		17. INFORMANT ADDRESS <b>Anna Brubaker, Hagerstown, Md.</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100 cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b></b>							
19a. DATE OF OPERATION <b></b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b></b>			
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>		21e. LOCATION STREET CITY OR TOWN COUNTY STATE <b></b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b></b>			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>A. White</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/26/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABDOL WHITEHEAD, MD</b>				22e. ADDRESS <b>1600 OAK HILL NE. Hgt. and</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>May 26, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Washington, Md.</b>	

24. FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b> ADDRESS <b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 31 1983</b>		25. REGISTRAR'S SIGNATURE <b>John J. Canine</b>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. A copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 4 3 2 6  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MARY E LAST BUSSARD		MONTH DAY YEAR May 21, 1983		12:00 M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		
F	WHITE	MONTH DAY YEAR June 6, 1901	81 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Monroe, Md.	U. S. A.	Washington	MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown	WESTERN MARYLAND CENTER		Housewife		Own Home
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Washington	Fairplay	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Rfd. 1 Box II 5 21783	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Edwin S. Mumma		FIRST MIDDLE LAST Mary Ellen Leatherman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT		
No		219-44-2739	ADDRESSES W. Wilson Blvd. Lucille M. Hoover, Hagerstown, Md. 21740		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pleural effusion &amp; cachexia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adenocarcinoma of the lung July 82</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (x) (this hospital) attended the deceased from <u>May 11</u> , 19 <u>83</u> , to <u>May 21</u> , 19 <u>83</u> , that (l) <u>xx</u> last saw the deceased alive on <u>May 20</u> , 19 <u>83</u> , and that in (my) <u>xxx</u> opinion death occurred on the date and hour and from the causes stated above. (l) <u>xx</u> did <u>xxx</u> view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Dr. U. Porciuncula M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		6/21/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Dr. U. Porciuncula		1500 Pennsylvania Ave., Hagerstown, Md. 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
Burial		5-24-83	Grossnickle Cemetery		Myersville, Fred. Co. Md.
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR		
NAME John H. Bast, Jr. Boonsboro, Md. 21713			MAY 24 1983		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 14327	
1. DECEASED NAME (TYPE OR PRINT) Raymond Sturgis CHAMBERS			2a. DATE OF DEATH MONTH DAY YEAR May 3, 1983		2b. HOUR M
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR April 29, 1900	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clearview Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) salesman	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Virginia		13b. COUNTY Arlington	13c. CITY OR TOWN Arlington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3106 N. Peary Street
14. FATHER'S NAME FIRST MIDDLE LAST Jesse Chambers		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma McKenzie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W.W.I 176-03-0153	17. INFORMANT ADDRESS Clara Chambers, Arlington, Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>retrocardiac coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from May 3, 19 83, to May 3, 19 83, that (1) (we) lost saw the deceased alive on May 3, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE L. W. H. D. R. O. N. M. D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/3/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. W. H. D. R. O. N. M. D.		22e. ADDRESS 138 E. Annapolis St.			
23a. BURIAL, CREMATION, REMOVAL burial	23b. DATE May 6, 1983	23c. NAME OF CEMETERY OR CREMATORY Lafayette Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Union Town, Fayette Co., Pa.	
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME		ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a. DATE REC'D. BY REGISTRAR MAY 9 1983	
				25b. REGISTRAR'S SIGNATURE John J. Lohr	

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10/11/11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 4 3 2 8 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Bernard A. Clark</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>5-20-83</b>		2b. HOUR <b>3:40 P.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 22, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MD.</b>		13c. COUNTY <b>WASH.</b>		13d. CITY OR TOWN <b>Hagerstown</b>		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS <b>201 Lily Dr.</b>		13g. ZIP CODE <b>21740</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>OCTAVIOUS LEE CLARK</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANN "WILKINSON"</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			
17. SOCIAL SECURITY NO. <b>218-03-2903</b>				18. INFORMANT <b>Helen Chaney/same as 13 e</b>				19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic Shock+Vent. Fibrillation immediate</b> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarction 4 weeks</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Artery Disease years</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Ventricular arrhythmias + Pulmonary Emboli</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4/23 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. DATE SIGNED <b>5-20-83</b>	
21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE		21j. DATE SIGNED <b>5-20-83</b>		21k. DATE SIGNED <b>5-20-83</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>5/17/83</b> to <b>5/20/83</b> , that (I) (we) last saw the deceased alive on <b>5/17/83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above <b>(we) did not</b> view the body after death.											
22b. SIGNATURE <b>W S Hood</b>				22c. ADDRESS <b>HAG., Md.</b>				22d. DATE SIGNED <b>5-20-83</b>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W S Hood</b>				22f. ADDRESS <b>HAG., Md.</b>				22g. DATE SIGNED <b>5-20-83</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5/24/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery Hagerstown, Wash., Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR <b>MAY 31 1983</b>			
24. FUNERAL DIRECTOR (NAME) <b>Rest Haven Funeral Chapel, Inc.</b>						24. REGISTRAR'S SIGNATURE <b>John J. Conner</b>					
25. ADDRESS <b>1601 Pennsylvania Ave./Hagerstown, Md.</b>						25. REGISTRAR'S SIGNATURE <b>John J. Conner</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

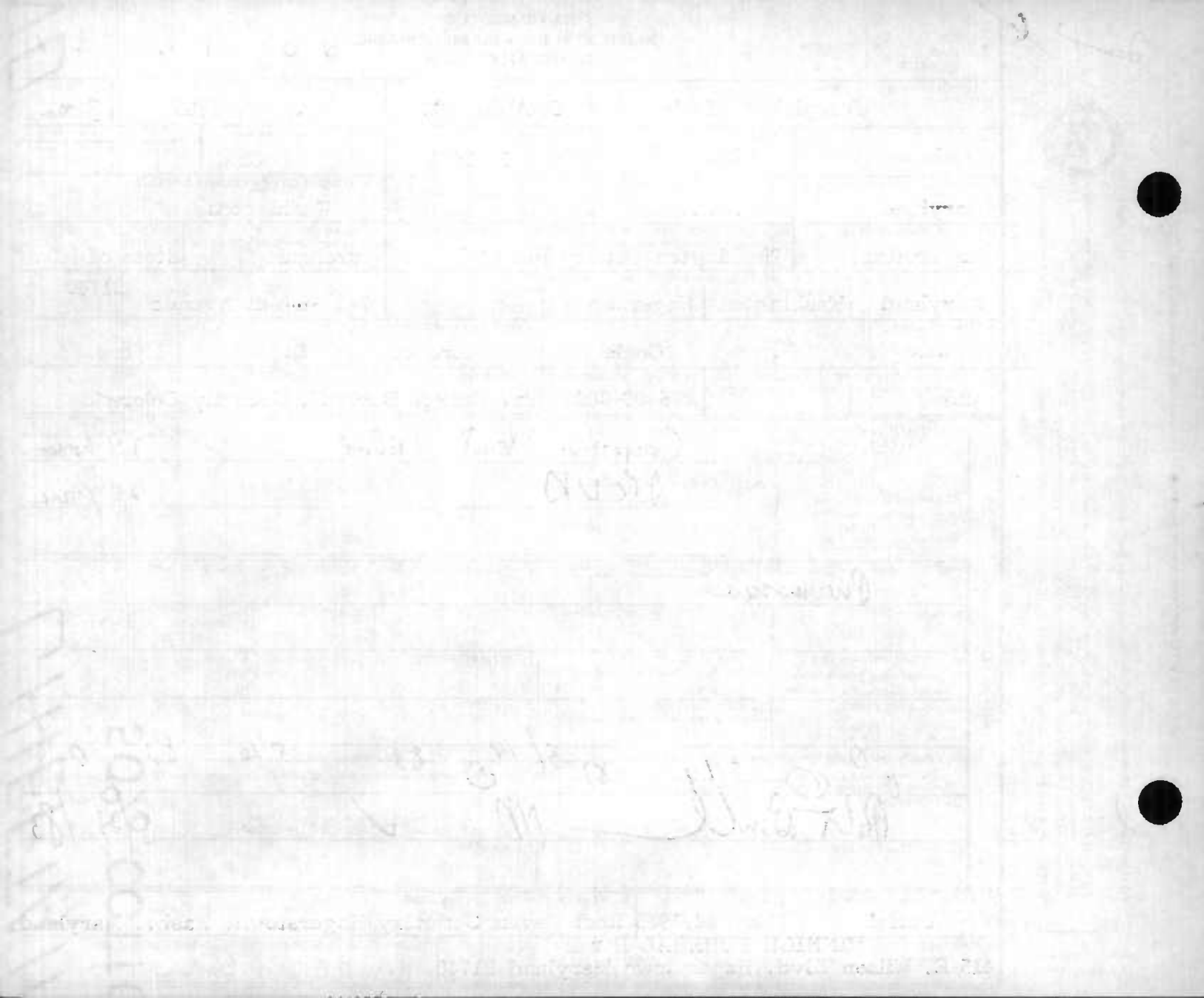
FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 4 3 2 9  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph Irvin COALE, SR.			2a. DATE OF DEATH MONTH DAY YEAR May 20, 1983			2b. HOUR 3:00 a.m.		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 5, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) purchasing		12b. KIND OF BUSINESS OR INDUSTRY State of MD.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph G. Coale			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence E. Myers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-09-0881		17. INFORMANT ADDRESS Mr. George Dayhoff, Security Colorado			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours 20 years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Pneumonia</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from <u>5/19/83</u> to <u>5/20/83</u> that (we) last saw the deceased alive on <u>5/19/83</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>[Signature]</u> MD				22c. DATE SIGNED 5/23/83		22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE May 24, 1983		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland		
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME NAME ADDRESS 415 E. Wilson Blvd., Hagerstown, Maryland 21740				25a. DATE REC'D. BY REGISTRAR MAY 26 1983		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 4 3 3 0 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>William Alonzo CUSTER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>May 9, 1983</b>				2b. HOUR M	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 18, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Colton Villa Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>sheet metal</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>aircraft</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Scott Custer</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emily Jackson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1916-1926</b>		17. INFORMANT ADDRESS <b>Ruth M. Custer, Hagerstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCD</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>A. W. Waheed</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Abdul Waheed, M.D.</b>				22e. ADDRESS <b>1600 Oak Hill Ave, Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>May 12, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>			
24. FUNERAL DIRECTOR'S NAME <b>MINNICH FUNERAL HOME</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 13 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canfield</b>			
415 E. Wilson Blvd., Hagerstown, Md. 21740									



1900-1901  
J. S. Yarn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 4 3 3 1 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Helen Jeannette Danzer</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>May 18 1983</b>				2b. HOUR M
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 31 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Williamsport</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Homewood Nursing Home</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John William Danner</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Edith Turner</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-09-6493</b>		17. INFORMANT ADDRESS <b>Greensburg, Pa. 15601</b> <b>Donald E. Shockey 108 Sherwood</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic small cell Carcinoma of lung</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>13 months</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>10/28 83</b> to <b>5/18 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Frederic H. Kass</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>5/20/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frederic H. Kass, III, M.D.</b>				22e. ADDRESS <b>1825 Howell Rd. Hagerstown, MD. 21740</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-21-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown Wash. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Gerald N. Minnich Hagerstown, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 23 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>		

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10

Female  
White  
U.S.A.  
Washington County  
Homewood  
Homewood  
1511 Oak Hill Avenue  
John William Farmer  
Mary Edith Farmer  
14-0-0432 Donald E. Crocker 100  
Greenland, 12, 1960

of lung

2/1/62 10/1/62

Frederic H. Kane, III, M.D.  
1825 Donald St., Lafayette, La. 70503  
2-21-65 Home Hill Cemetery, Monroe, La.  
303 N. Poydras St.  
Metairie, La. 70002



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <i>Hilmer Vernon Davis</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>5/1/83</i>					2b. HOUR <i>3:40 PM</i>	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>November 27, 1901</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>81</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.				
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>accountant</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Steel Co.</i>		
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>13 Park Avenue</i>		21740	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Edgar Davis</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna Lena Keckley</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>174-05-4470</i>		17. INFORMANT ADDRESS <i>Clara V. Davis, Hagerstown, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of right lung</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Pneumonia, Undermined, Arteriosclerotic CVH</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>6 June 19 72</i> to <i>date</i> <i>6 May 83</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Richard G. Benford, M.D.</i>				22c. ADDRESS <i>Hagerstown, Md.</i>				22d. DATE SIGNED <i>1 May 83</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>				23b. DATE <i>May 4, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash. Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i>						25a. DATE REC'D. BY REGISTRAR <i>MAY 3 1983</i>		25b. REGISTRAR'S SIGNATURE <i>Joan S. Smith</i>			
415 E. Wilson Blvd., Hagerstown, Md. 21740											





CHIEF  
CLERK  
RECEIVED  
JUN 10 1964

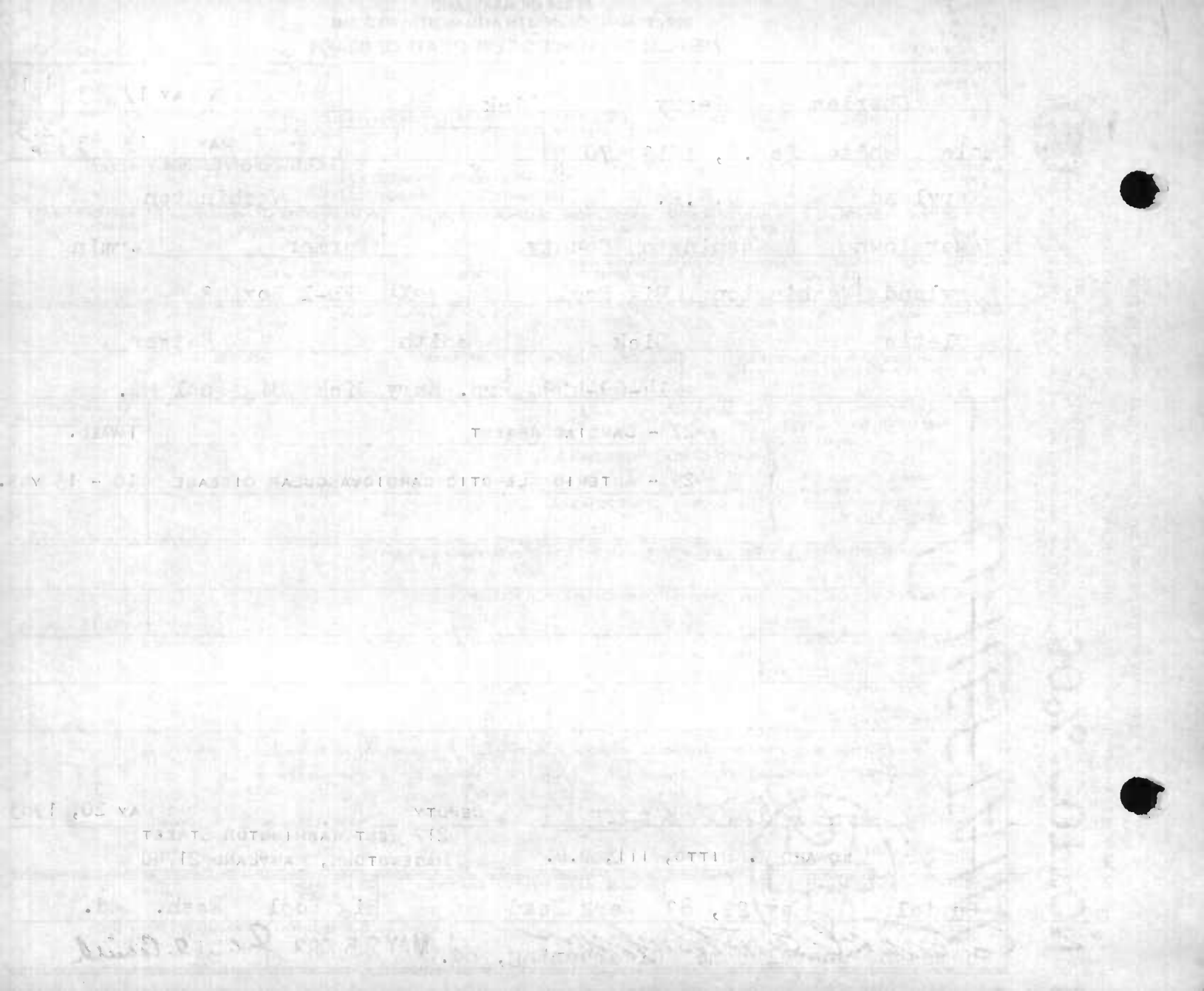
MAILED 100 JUN 10 1964

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										3	REG. NO.	4	3	3	3
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Charles Perry Dick</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MAY 19 1983		7a. HOUR 1:10 P M			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 2, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YR. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>MAY 19 1983</b>		7b. HOUR 2:30 P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Washington</b> 13c. CITY OR TOWN <b>Big Pool</b>										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>RFD-1 Box 43 21711</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Cletis Dick</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edith Hetzer</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>214-09-4098</b>		17. INFORMANT ADDRESS <b>Mrs. Mary Dick Big Pool Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>#427 - CARDIAC ARREST</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>#429 - ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMED.</b> <b>10 - 15 YRS.</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>Edward W. Ditto</i>				TITLE (SPECIFY) <b>DEPUTY</b>				DATE <b>MAY 20, 1983</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>EDWARD W. DITTO, III, M.D.</b>				ADDRESS <b>217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>May 22, 83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Park Head</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Big Pool Wash. Md.</b>							
FUNERAL DIRECTOR <i>Thompson Funeral Home</i>						25a. DATE REC'D. BY REGISTRAR <b>MAY 25 1983</b>									
25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 335-9121.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8314334	
1- FOR STATE REGISTRAR										2a DATE OF DEATH MONTH DAY YEAR	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Robert FRANCIS DIFFENDAL</b>										5-1-83	
3 SEX M 4 RACE W. 5 DATE OF BIRTH MONTH DAY YEAR 10-5-11										6 AGE (IN YEARS LAST BIRTHDAY) 71	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b CITIZEN OF WHAT COUNTRY? USA										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.										12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) salesman	
10 CITY OR TOWN OF DEATH Hagerstown 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Center										12b KIND OF BUSINESS OR INDUSTRY Sears	
13a STATE Maryland 13b COUNTY Washington 13c CITY OR TOWN Hagerstown										13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Charles D. Diffendal										15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie B. Myerly	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No 16b SOCIAL SECURITY NO. 214-09-3096										17 INFORMANT ADDRESS Mrs. M. Frances Diffendal, Hagerstown, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest, Maxillo HYO</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac infarct?</u> Generalized arterio Cardiovascular disease years DUE TO, OR AS A CONSEQUENCE OF (c) <u>Q myocardial</u> 10 years.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10											
19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f LOCATION STREET CITY OR TOWN COUNTY STATE											
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/30/73 19 to 5/1/83 19, that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 4-30-83 19 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.											
22b SIGNATURE <u>Mikani M. M. D.</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> 22c DATE SIGNED 5-1-83											
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>MIKANI M. M. D.</u> 22e ADDRESS											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) 23b DATE May 4, 1983 23c NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery 23d LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington, Md.											
24 FUNERAL DIRECTOR'S NAME <u>MINNICH FUNERAL HOME</u> ADDRESS <u>415 E. Wilson Blvd., Hagerstown, Md. 21740</u> DATE REC'D BY REGISTRAR 25 REGISTRAR'S SIGNATURE <u>John J. Calver</u>											



MAY 3 1983  
J. G. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 4 3 3 5 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES AUGUSTINE FAITH</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>May 16, 1983</b>				2b. HOUR <b>5:13P<sub>M</sub></b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1/26/1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b>		IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		IF UNDER 24 HRS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Co. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Sand Mfg.</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Washington</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>262 W. Main Street</b>		13f. ZIP CODE <b>21750</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William J. Faith, Jr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Molly English</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W. 11</b>		17. INFORMANT ADDRESS <b>Hazel B. Faith same as 13.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute M.I.</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>10 yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cancer of prostate</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>March 10, 1983</b> to <b>April 5, 1983</b> , that (I) (we) lost saw the deceased alive on <b>April 5, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>FB Thomas III MD</b>						DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>05-17-83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frank B Thomas, III, M.D., P.A.</b>						22e. ADDRESS <b>Two Tonoloway Hancock, Md. 21750</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>5/19/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Catholic</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hancock Washington Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Kushner &amp; Son</b>						ADDRESS <b>HANCOCK MD</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 31 1983</b>			

any of these have been investigated

et al. 1990

62-71-20



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the Registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		83 14336 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Fleming, Joan Louise						2a. DATE OF DEATH MONTH DAY YEAR 5-26-83		2b. HOUR 9:22 AM	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1 24 38		6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Williamsport		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2711 Virginia Avenue 21795	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Forsythe				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Luella Meadows					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-34-0317		17. INFORMANT ADDRESS Joseph H. Fleming, Williamsport, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Congestive Failure DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Minutes 5 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) Cirrhosis of Liver									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W W Lusk MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE May 28, 1983		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clear Spring, Wash. Maryland			
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME				25a. DATE REC'D. BY REGISTRAR MAY 31 1983					
415 E. Wilson Blvd., Hagerstown, Md. 21740				REGISTRAR'S SIGNATURE Joan J. Smith					

UNITED STATES GOVERNMENT  
DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/B1  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3

REG. NO.

1 4 3 3 7

1. DECEASED NAME (TYPE OR PRINT) <b>Virginia M. Feltz</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>05 14 83</b>			2b. HOUR <b>8:45 AM</b>					
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05 20 12</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.					
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WESTERN MARYLAND CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ribbon Company</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY <b>Wash</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>21740 S. Locust</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Wade Rohrer</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leila Unger</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>220-26-5165</b>	
16c. INFORMANT <b>Mrs. Patricia Higham, Alloway, New Jersey</b>											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic shock</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary emboli</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Days</b> <b>Yrs</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (X) (this hospital) attended the deceased from <b>5/10/83</b> , to <b>5/14</b> , 19 <b>83</b> , that (I) <del>XX</del> last saw the deceased alive on <b>5/14</b> , 19 <b>83</b> , and that in (my) <del>(XX)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>XX</del> (did) <del>(XX)</del> view the body after death.											
22b. SIGNATURE <b>KYUNG S. KIM</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>5/14/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KYUNG S. KIM</b>			22e. ADDRESS <b>1500 Penna. Ave Hagerstown, Md. 21740</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>			23b. DATE <b>May 18, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beaver Creek Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Beaver Creek, Wash., Md.</b>			
24 FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b>			ADDRESS <b>415 East Wilson Blvd., Hagerstown, Maryland 21740</b>			25. DATE RECEIVED BY REGISTRAR AND REGISTRAR'S SIGNATURE <b>MAY 19 1983 John J. Gierke</b>					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 30 1 4 3 3 8 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>VIRGINIA LEE FRYE</b>				2a. DATE OF DEATH MONTH <b>MAY</b> DAY <b>24</b> YEAR <b>1983</b>				2b. HOUR <b>30</b> <b>8 A.M.</b>			
3. SEX <b>F</b>		4. RACE <b>W.</b>		5. DATE OF BIRTH MONTH <b>JULY</b> DAY <b>19</b> YEAR <b>1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Sewing</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Williamsport</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>154 N. Artizan St.</b>			
14. FATHER'S NAME FIRST <b>Mathias</b> MIDDLE <b>H.</b> LAST <b>Frye</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Rebecca</b> MIDDLE <b></b> LAST <b>?</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>232-01-1449</b>		17. INFORMANT <b>Mr. Carl Frye</b>				ADDRESS <b>Garling Texas</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURED AORTIC ANEURYSM</b> <b>4416</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>											
19a. DATE OF OPERATION <b>9-24</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>9-24</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>P.M.</b> <b>19</b>				21b. TIME OF INJURY HOUR <b></b> A.M. <b></b> MONTH <b></b> DAY <b></b> YEAR <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b></b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>				21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>9-24</b> , 19 <b>79</b> , to <b>5-24</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>MAY 23</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John R. Melnick</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>5/24/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John R. Melnick</b>				22e. ADDRESS <b>16220 Frederick Rd., Gaithersburg, MD 20760</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>May 27, 83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn</b>		23d. LOCATION CITY OR TOWN <b>Hag.</b> COUNTY <b>Wash.</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR <b>Donald E. Thompson</b>				25a. DATE REC'D BY REGISTRAR <b>MAY 31 1983</b>				25b. REGISTRAR'S SIGNATURE <b>D. E. Thompson</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 3 1 4 3 3 9 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Inis Fern FUNKHOUSER				2a. DATE OF DEATH MONTH DAY YEAR May 13, 1983				2b. HOUR M	
3. SEX female		4. RACE white		5. DATE OF BIRTH February 23, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) metal processor		12b. KIND OF BUSINESS OR INDUSTRY aircraft	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 125 Overhill Drive 21740			
14. FATHER'S NAME FIRST MIDDLE LAST Edward Kelley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Weller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 162-07-9638		17. INFORMANT ADDRESS Mrs. Fay Brandt, Greencastle, Pennsylvania					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) ACUTE RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ATRIAL FIBRILLATION & RENAL ARTERY CHAOS 2 WEEKS DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLECTIC HEART DISEASE PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a CARCINOMA OF BREAST								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 12-21, 19 70, to 5-13, 19 83, that (1) (we) last saw the deceased alive on 5-13, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-16-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY M. COHEN		22e. ADDRESS 339 E ANTIETAM ST HAGERSTOWN, MD, 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE May 16, 1983		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clear Spring, Wash., Maryland			
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME ADDRESS				25a. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE) MAY 19 1983 [Signature]					
415 East Wilson Blvd., Hagerstown, Maryland 21740									

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RECEIVED  
JAN 10 1964  
U.S. AIR FORCE



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 3 1 4 3 4 0 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>NELSON SIDNEY GARLING, SR.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>5 24 83</b>		2b. HOUR <b>10<sup>08</sup> P.M.</b>			
3. SEX <b>M</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 23 12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b> MD.			
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON COUNTY HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>	
13a. STATE <b>MD</b>				13b. COUNTY <b>WASHINGTON</b>		13c. CITY OR TOWN <b>HAGERSTOWN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry M. Garling</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary G. Bryan</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>214-09-2870</b>		17. INFORMANT ADDRESS <b>Jane Garling, Hagerstown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Pulmonary Arrest</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Intractable Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Eugene Waples</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>5-27-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>May 31, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b>				ADDRESS <b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 31 1983</b>			
25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>									



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 4 3 4 1 REG. NO.							
1- FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>REUBEN GLADFELTER</b>				<b>5-7-83</b>				<b>8<sup>00</sup> P M</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec 8, 1896</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>86</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington MD.</b>					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Western Maryland Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>				13b. COUNTY <b>Wash.</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1500 Pa. Ave. 21740</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>219-54-3131J1</b>		17. INFORMANT ADDRESS <b>Western Md. Center Hagerstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>① Heart Failure</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>② Post CVA Recent</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <b>③ generalized ASVD</b> <b>④ Petromite Brain cysts</b> <b>years.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours - 6000</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that (XX) (this hospital) attended the deceased from <b>3/25/81</b> to <b>5/7/83</b> saw the deceased alive on <b>5/7/83</b> and that in (my) (XX) opinion death occurred on the date and hour and from the causes stated above. (I) (XX) (did) (did not) view the body after death.											
22b. SIGNATURE <b>milamir me</b>				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>				23b. DATE <b>May 11, 83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash, Md.</b>			
24. FUNERAL DIRECTOR <b>Davis Funeral Home P.A. Smithsburg, Md.</b>						25a. DATE RECEIVED BY REGISTRAR <b>MAY 23 1983</b>					

BP



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 3 1 4 3 4 2 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rose (NMN) GOLL					2a. DATE OF DEATH MONTH DAY YEAR May 21 - 1983			2b. HOUR 11A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 26, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 90		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czechoslovakia		7b. CITIZEN OF WHAT COUNTRY? Czechoslovakia		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ravenwood Lutheran Village				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 201 Wesley Dr. 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Wenzel - Zajic			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie - Ryba						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS Mr. Adolph Zajic, Hagerstown, Md., 21740				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dissecting Aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>High Arterial Blood Pressure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN STREET COUNTRY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/7 1983 to 5/21 1983, that (I) (we) lost say the deceased alive on 5/21 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Edmund Hovester</u> DEGREE <u>MD</u>						22c. DATE SIGNED <u>5-21-83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>EDMUND HOVESTER</u>						22e. ADDRESS <u>FUNKS TOWN MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 25 1983		23c. NAME OF CEMETERY OR CREMATORY Cemetery Poughkeepsie Rural		23d. LOCATION CITY OR TOWN COUNTY STATE Poughkeepsie Dutchess N.Y.		
24. FUNERAL DIRECTOR NAME <u>Davis</u>						25a. DATE REC'D. BY REGISTRAR <u>JUN 3 1983</u> REGISTRAR'S SIGNATURE <u>John J. Smith</u>			
Davis Funeral Home, Smithsburg, Maryland 21783									

MEDICAL CERTIFICATION



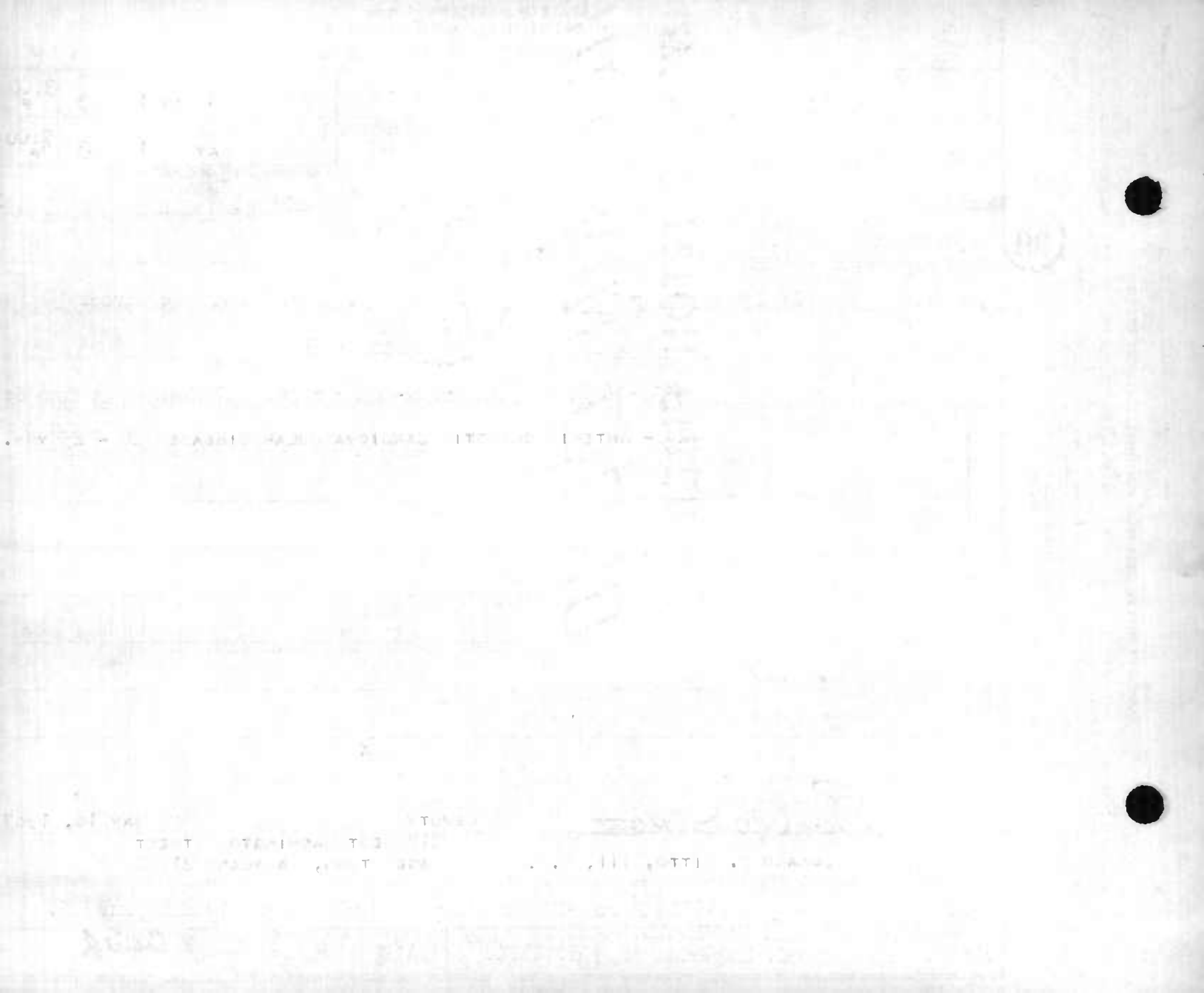


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 77 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR 15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14343
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) <b>THOMAS NMN GREENE</b>						2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>MAY 15 1983</b>		2b. HOUR <b>3:00 P M</b>		
1. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH <b>unknown</b> DAY <b>unknown</b> YEAR <b>unknown</b>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>unknown</b>	IF UNDER 1 YR. MONTHS <b>unknown</b> DAYS <b>unknown</b>	IF UNDER 24 HRS. HOURS <b>unknown</b> MIN. <b>unknown</b>	7c. DATE PRONOUNCED DEAD <b>MAY 15 1983</b>		7d. HOUR <b>7:00 P M</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>117 South Potomac St.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
11a. STATE <b>Maryland</b>		11b. CITY <b>Washington</b>		11c. CITY OR TOWN <b>Hagerstown</b>		11d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11e. STREET ADDRESS <b>117 South Potomac Street</b>		
14. FATHER'S NAME FIRST <b>Thomas</b> MIDDLE <b>Greene</b> LAST <b>Greene</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Carrie</b> MIDDLE <b>Bell</b> LAST <b>Bell</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. <b>215-16-6794</b>			17. INFORMANT ADDRESS <b>Charlotte M. Greene 117 South Potomac St</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>#429 - ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 - 25 YRS.</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE <b>Edward W. Ditto</b>			TITLE (SPECIFY) <b>DEPUTY</b> MEDICAL EXAMINER			DATE SIGNED <b>MAY 16, 1983</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>EDWARD W. DITTO, III, M.D.</b>			ADDRESS <b>217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740</b>							
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>May 18, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown Washington Md.</b>				
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME</b> NAME <b>415 E. Wilson Blvd. Hagerstown, Md. 21740</b> ADDRESS						25a. DATE REC'D. BY REGISTRAR <b>MAY 19 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified ~~in writing~~

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR		3. SEX			
HARRY ELMER GROSS		5-6-83		5:50 PM		M.			
4. RACE		5. DATE OF BIRTH		6. AGE		7b. BIRTHPLACE			
W.		Nov. 21, 1899		83		Frederick Co., Md.			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Washington		Hagerstown		WESTERN MARYLAND CENTER			
12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Farmer		Farming		Maryland		Washington		Boonsboro	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
George		Sarah		No		220-34-2469		Mrs. Hazel L. Gross, Boonsboro, Md.	
18. CAUSE OF DEATH		19. DATE OF OPERATION		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING	
4280		4/29/83		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
DUE TO, OR AS A CONSEQUENCE OF		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED		21e. PLACE OF INJURY	
Congestive Heart Failure		5:00 AM		FALLING FROM		AT HOME		AT HOME	
DUE TO, OR AS A CONSEQUENCE OF		21f. LOCATION		22a. I certify that (X) (this hospital) attended the deceased from		22b. SIGNATURE		22c. DATE SIGNED	
Chronic CHF		CITY OR TOWN		4/29/83		MILANINI		5/6/83	
Dehydration		COUNTY		5/6/83		MILANINI		5/6/83	
Atrial Fibrillation		STATE		5/6/83		MILANINI		5/6/83	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		22d. PHYSICIAN'S NAME		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL		23b. DATE	
		MILANINI		1500 Pennsylvania Ave NW		Burial		5-9-83	
		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. NAME OF CEMETERY OR CREMATORY		23f. DATE	
		Benevola Cemetery		Benevola, Wash. Co., Md.		Benevola Cemetery		5-9-83	
		24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE	
		John H. Bast, Jr.		MAY 11 1983		John J. Conner		MAY 11 1983	



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W. C. A. ...

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Washington ...

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John H. ...

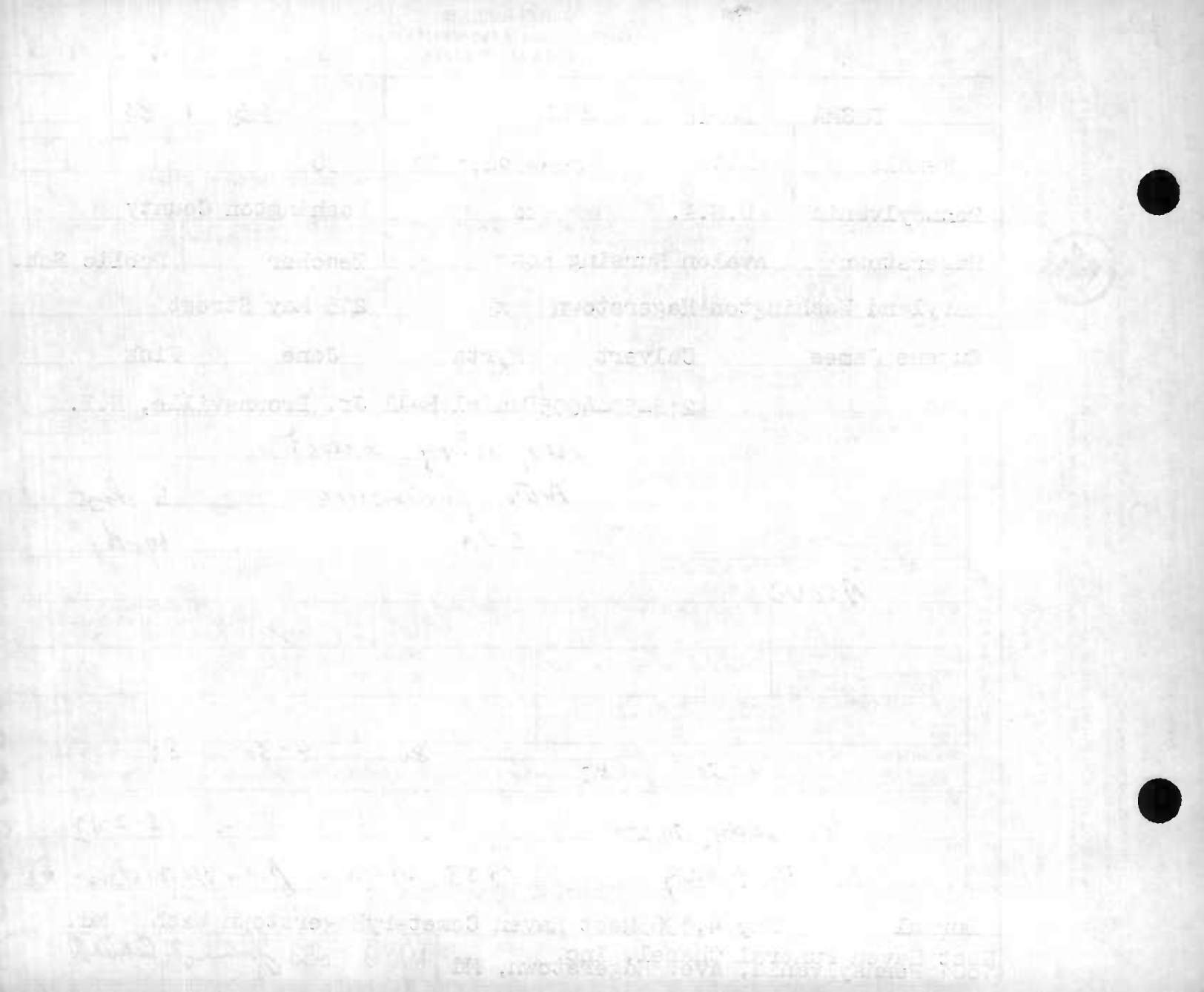
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 (shows any injury, or other traumatic event, the medical examiner must be notified at once).

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		8 3		1 4 3 4 5		REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) DESMA Doris HALL					2a. DATE OF DEATH MONTH DAY YEAR May 1 83			2b. HOUR M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 24, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Avalon Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Public Sch.		
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 215 May Street 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Eugene James Calvert			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrta Jane Fisk			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				
16b. SOCIAL SECURITY NO. 218-50-4005			17. INFORMANT ADDRESS Daniel Hall Jr. Brownsville, N.Y.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CVA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>5 days</u> <u>month</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>ASCVD</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 19 80, to 4-30 19 82, that (I) (we) last saw the deceased alive on 4-30 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE L. Ray M.D.			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 5-2-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. B. RANK			22e. ADDRESS 1933 Virginia Ave., Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 4, 1983		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Md.			
24. FUNERAL DIRECTOR Rest Haven Funeral Chapel, Inc. 1601 Pennsylvania, Ave. Hagerstown, Md			25a. DATE REC'D. BY REGISTRAR MAY 9 1983		25b. REGISTRAR'S SIGNATURE John J. Lohr					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND											
DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
CERTIFICATE OF DEATH											
REG. NO. 8 3 1 4 3 4 6											
1. DECEASED NAME (TYPE OR PRINT) <i>HARRY</i>		FIRST <i>CLEVELAND</i>		MIDDLE <i>HARRISON</i>		LAST <i>HARRISON</i>		20. DATE OF DEATH MONTH DAY YEAR <i>5-22-83</i>		2b. HOUR <i>12:00</i> M.	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Dec. 19, 1889</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>93</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.					
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>71 Scott Hill Drive</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>carpenter</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>building</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>71 Scott Hill Drive</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Mahlon Harrison</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Susan Betts</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>214-09-1148</i>		17. INFORMANT ADDRESS <i>Ruth M. Pryor, Hagerstown, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>acute myocardial infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>arteriosclerosis</i> <i>arteriosclerosis</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>none</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>11 7 68</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>5-22-83</i> 19 <i>83</i> to <i>5-22-83</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>5-22-83</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>E. R. Roldizabon</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>5-23-83</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. R. Roldizabon</i>		22e. ADDRESS <i>382 John Street, Hagerstown, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>May 24, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash. Maryland</i>					
24. FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i>		ADDRESS <i>415 E. Wilson Blvd., Hagerstown, Md. 21740</i>				25. DATE REC'D BY REGISTRAR <i>MAY 25 1983</i>					



Blank lined paper with two binder holes on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 14347 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST Rev. Russell Earl Hartle				2b. HOUR M			
3 SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR October 20, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. CITY OR TOWN Washington		13c. STREET ADDRESS Public Square 21740 Alexander House	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Hartle				15. MOTHER'S MAIDEN NAME FIRST MIDDLE Ruth M. Forsythe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. W.W.I 275-09-8222		17. INFORMANT ADDRESS Mr. Russell Hartle, Jr., Hagerstown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mult. leukemia IgG kappa subtype</u> 4 months 2030 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Pneumonia - congestive heart failure</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-13-83, to 5-5-83, that (we) last saw the deceased alive on 5-5-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Joseph Secomdari				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5.5.83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH SECOMDARI				22e. ADDRESS BOONSBORO 21713			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE May 9, 1983		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740				25a. DATE REC'D. BY REGISTRAR MAY 11 1983			
				25b. REGISTRAR'S SIGNATURE John J. Connel			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83

REG. NO.

14348

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) <i>(Merle) MENTE E. Hawbaker</i>		2a. DATE OF DEATH		5 14 83		2b. HOUR 2:00 PM	
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
		MONTH DAY YEAR <i>9 29 31</i>		51		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Penna.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington Co., MD.</i>			
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Co. Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>Army Depot Worker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Def.</i>		
13a. STATE <i>Pa.</i>		13b. COUNTY <i>Franklin</i>		13c. CITY OR TOWN <i>Mercersburg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. STREET ADDRESS			
FIRST MIDDLE LAST <i>Fred L. Hawbaker</i>		FIRST MIDDLE LAST <i>Bessie V. Bowers</i>		11729 Two Top Rd. 99999			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>1952-55 208-24-1225</i>		17. INFORMANT <i>Mrs. Arlene Hawbaker</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18a. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4310 IMMEDIATE CAUSE (a) <i>coronary arrest</i>							
DUE TO, OR AS A CONSEQUENCE OF		(b) <i>cerebral hemorrhage</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Joseph R. Wilson</i>		DEGREE		22c. DATE SIGNED <i>5/14/83</i>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph R. Wilson</i>		22f. ADDRESS <i>1195 KENLY AVE. Hgt. Rd</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5/18/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Welsh Run Breth.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Mercersburg Franklin Pa.</i>	
24. FUNERAL DIRECTOR <i>J. M. Linger</i>		Mercersburg, Pa.		25a. DATE REC'D. BY REGISTRAR <i>MAY 18 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		8 3		1 4 3 4 9		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Charles Millard Hays Sr.				May 23 83		11:20 P.M.							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
male		white		Dec. 25, 1906		76		YRS.		MONTHS		DAYS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				Washington						MD.	
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown		Washington County Hospital											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Washington		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		36 Coffman Ave.		21740			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST				FIRST MIDDLE LAST									
William B. Hays, Sr.				Minnie M. Showe									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS			
No				214-09-3703		Catherine M. Hays, Hagerstown, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Anteroseptal Coronary Vessel Disease DUE TO, OR AS A CONSEQUENCE OF (c) Probable Myocardial Infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days 10 years 20 years													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Multiple Small Cerebrovascular Accidents													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/11/83 to 5/22/83, that (we) lost saw the deceased alive on 5/23/83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Robert Brull													
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Brull													
22d. ADDRESS 1459 Potomac Avenue													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
burial				May 26, 1983		Rose Hill Cemetery		Hagerstown, Wash., Maryland					
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740													
25. DATE RECD. BY REGISTRAR JUN 01 1983													
25b. REGISTRAR'S SIGNATURE John J. Caniff													

Charles M. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 4 3 5 0 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) Guy Edgar Hoffman				2a. DATE OF DEATH MONTH DAY YEAR 5 24 1983		2b. HOUR 7:15 A M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 6, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clerk		12b. KIND OF BUSINESS OR (stationary store) Hays, Inc.	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles E. Hoffman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Ellen Bowman		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-09-2036	
				17. INFORMANT ADDRESS Mary F. Hoffman, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes 12 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Diabetes Mellitus. Peripheral vascular disease. Hypertensive vascular disease.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>(W. T. Layman)</u> attended the deceased from <u>5/17</u> , 19 <u>83</u> , to <u>5/24</u> , 19 <u>83</u> , that (I) <u>xx</u> saw the deceased alive on above, (I) <u>xx</u> (did) <u>xx</u> view the body after death.							
22b. SIGNATURE <u>W. T. Layman, M.D.</u> 22b. PHYSICIAN'S NAME (TYPE OR PRINT)				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/26/83	
22b. ADDRESS W. T. Layman, M.D.				301 E. Antietam St., Hagerstown, MD. 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE May 27, 1983		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a. DATE REC'D. BY REGISTRAR MAY 31, 1983			
				25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>			

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MISSION FOR ALPHABET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Delores		Yvonne		HOLDER				May 22, 1983		11:07 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
female		white		MONTH DAY YEAR Sept. 25, 1932		50 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Washington MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Washington County Hospital						housewife			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
W. Va.		Berkeley		Falling Waters				Sportsmens Paradise			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Lawson				Keller				Isabelle Kneisley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				215-26-7966		Glen W. Holder, Falling Waters, W. Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) CARCINOMA OF VAGINA WITH PELVIC METASTASIS										2 YEARS	
1840 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) <del>XXXXXX</del> attended the deceased from <u>AUG. 20</u> , 19 <u>82</u> , to <u>MAY 22</u> , 19 <u>83</u> , that (I) <del>XXXX</del> last saw the deceased alive on <u>MAY 22</u> , 19 <u>83</u> , and that in (my) <del>XXXX</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>XXXXXX</del> view the body after death.											
22b. SIGNATURE <i>Edward W. D. Ditto</i>				DEGREE				22c. DATE SIGNED MAY 23, 1983			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.				22e. ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
burial		May 25, 1983		Brownsville Cemetery		Brownsville, Wash., Maryland					
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740						25a. DATE RECEIVED BY REGISTRAR JUN 30 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Chief</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 4 3 5 2 REG. NO.			
1. FOR STATE REGISTRAR					1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR a.	
					MILBURN A. HOLLENGREEN					May 29, 1983		11:50 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 2 1903		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief Executive		12b. KIND OF BUSINESS OR INDUSTRY Tool Co.			
13a. STATE Penna.		13b. COUNTY Franklin		13c. CITY OR TOWN Waynesboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 205 Clayton Ave.					
14. FATHER'S NAME FIRST MIDDLE LAST Alfred B. Hollengreen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alfreda H. Ostrom									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 173-03-0455		17. INFORMANT ADDRESS Mrs. M.A. Hollengreen 205 Clayton Ave., Waynesboro, Pa. 17268							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) Cerebro-Vascular Accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. certify that (I) (we) signed and attended the deceased from 5-13, 19 83, to 5-29, 19 83, that (I) (we) last saw the deceased alive on 5-29, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Eric M. Wagshal								DEGREE M.D.		22c. DATE SIGNED May 30, 1983			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric M. Wagshal								22e. ADDRESS 1825 Howell Rd. Hagerstown, Md. 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE June 1, 1983		23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Waynesboro Franklin Pa.					
24. FUNERAL DIRECTOR NAME Michael G. Cox						ADDRESS Waynesboro, Penna.		25a. DATE REC'D. BY REGISTRAR JUN 6 1983		25b. REGISTRAR'S SIGNATURE John J. Conrad			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		83		14353		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) THELMA FENWICK HOWE				2a. DATE OF DEATH MONTH DAY YEAR May 3, 1983				2b. HOUR A. 10:10 M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Sept. 28, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON COUNTY MD.			
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 214 Foxcroft Circle				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian		12b. KIND OF BUSINESS OR INDUSTRY Library	
13a. STATE MARYLAND		13b. COUNTY WASH.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21740 214 Foxcroft Circle	
14. FATHER'S NAME FIRST MIDDLE LAST RICHMOND WM. KELLY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA IRENE "KELLY" KELLY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. ----- 262-68-2897		17. INFORMANT ADDRESS NANCY BRIGGS/same as 13 e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY 1629 IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9/20</u> , 19 <u>82</u> , to <u>4/3</u> , 19 <u>83</u> , that (I) (we) lost <u>3/2</u> <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Frederic H. Kass</u>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/4/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederic H. Kass M.D.				22e. ADDRESS 1825 Idwell Rd - Hagerstown					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 5/4/83		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematorium, Wash. Md.		23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg, Wash. Md.			
24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc. 1601 Pennsylvania Ave., Hagerstown, Md.				25. DATE REC'D. BY REGISTRAR MAY 9 1983					

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return this certificate to the hospital or attending physician.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83  
REG. NO.

14354

1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 3 1 4 3 5 4	
1 DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Helen Irene JOHNSON		May 28, 1983		1:30 P.M.	
3 SEX		4 RACE		5. DATE OF BIRTH	
female		white		March 29, 1908	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		U.S.A.		9 BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Hagerstown		215 West Washington Street		meat department	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Washington		Hagerstown	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
George J. Schmidt		Elsie Andrews		no	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:	
213-42-1349		Mr. Kenneth L. Johnson, Brighton, Colorado		1579 IMMEDIATE CAUSE (a) Carcinoma Pancreas	
				DUE TO, OR AS A CONSEQUENCE OF	
				DUE TO, OR AS A CONSEQUENCE OF	
				DUE TO, OR AS A CONSEQUENCE OF	
				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)	
				Arteriosclerotic Cardiovascular Disease	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from Apr 22, 1983, to May 28, 1983, that (I) (we) lost the deceased on May 22, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED	
		Edward W. Ditto, III, M.D.		May 29, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Edward W. Ditto, III, M.D.		217 W. Washington Street, Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
burial		May 31, 1983		Rose Hill Cemetery	
		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR	
		Hagerstown, Wash., Maryland		JUN 3 1983	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
MINNICH FUNERAL HOME				John J. Connel	
415 E. Wilson Blvd., Hagerstown, Maryland 21740					

RECEIVED  
JUN 3 1968



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JUN 3 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 14355 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Margaret Louise Kave</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>5 29 83</i>		2b. HOUR <i>M</i>	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 14 1904</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>78</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>W. Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>Washington County Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>Housewife</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>Maryland Washington Boonesboro</i>				13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS <i>2 South Main Street</i> 21713	
14. FATHER'S NAME <i>Joseph Benton Howell</i>				15. MOTHER'S MAIDEN NAME <i>Katie Lee Moore</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>		16b. SOCIAL SECURITY NO. <i>234-66-8021</i>		17. INFORMANT <i>Bernard Kave</i>			
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute and chronic renal failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Gram positive sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Congestive Heart Failure</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>~100 hours</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Multiple Myeloma</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>7/ 19 83</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 28, PART 3, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <i>5/29 1983</i> to <i>5/29 1983</i> that (1) (we) last saw the deceased alive on <i>5/29 1983</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) not view the body after death.							
22b. SIGNATURE <i>R.L. Kugler</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/30/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R.L. Kugler MD</i>				22e. ADDRESS <i>Gecting Lane Keedysville, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6-2-83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lutheran Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Uvilla Jeff. W. Va.</i>	
24. FUNERAL DIRECTOR NAME <i>Douglas R. Snowden</i>				25. DATE REC'D. BY REGISTRAR <i>JUN 8 1983</i>			
26. REGISTRAR'S SIGNATURE <i>Joan Z. Canfield</i>							

James G. Thompson

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BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 83 14356

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) HAZEL ALDENE KEGARISE		MONTH DAY YEAR May 28, 1983		10:59 AM	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH April 2, 1917	6. AGE (IN YEARS LAST BIRTHDAY) 66	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook	12b. KIND OF BUSINESS OR INDUSTRY Resturant		
13a. STATE Md.....		13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Carlton Eugene Gibson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ora "Nudamaker"			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-22-6926		17. INFORMANT ADDRESS Hagerstown Charlotte J. Mellott/Rt6 Box 344	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (Massive) Cerebro-Vascular Accident 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ?					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Anteriosclerotic Heart Disease & Congestive Failure & Anasarca - Diabetes Mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22. I certify that (I) (this hospital) attended the deceased from April 16, 1976, to 28 May, 1983, that (I) (we) lost saw the deceased alive on 27 May, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE DEGREE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
W. M. Fender M.D.		30 May 83		22e. ADDRESS 138 E. Antietam St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/1/83		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery Hagerstown, Wash. Md.	
23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR Rest Haven Funeral Chapel, Inc. 1601 Pennsylvania Ave. Hagerstown, Md.			
25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
JUN 8 1983		John J. Calkins			

First Name: Rose Hill Cemetery in Spring, Wash. D.C.  
Last Name: Rose Hill Cemetery in Spring, Wash. D.C.  
Address: Rose Hill Cemetery in Spring, Wash. D.C.

W. H. Taylor

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 2 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3	1 4 3 5 7
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas C Kelley Sr					2a. DATE OF DEATH MONTH DAY YEAR May 11 1983			2b. HOUR 5:30a M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 31 1895		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.					
10. CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Homewood Retirement Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer		12b. KIND OF BUSINESS OR INDUSTRY Newspaper			
13a. STATE West Virginia		13b. COUNTY Berkeley		13c. CITY OR TOWN Martinsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1004 Mill Race Drive 99999			
14. FATHER'S NAME FIRST MIDDLE LAST E. E. Kelley					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sutton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W W I 509-09-4456		17. INFORMANT ADDRESS Carolyn Brown 1004 Mill Race Dr. Martinsburg, WV 25401							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY 2500 IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized ASCVD</u> (c) <u>Diabetes mellitus</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
9a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>R.L. Kugler MD</u>			DEGREE COVERING MD.			ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/12/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.L. Kugler			22e. ADDRESS 100 Geeting Lane Keedysville, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Pleasant View Memory Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Martinsburg Berkeley WV				
24. FUNERAL DIRECTOR Brown Funeral Home			24b. ADDRESS 327 W. King St. P.O. Box 82 Martinsburg, WV 25401			25a. DATE REG'D BY REGISTRAR MAY 16 1983					
25b. REGISTRAR'S SIGNATURE <u>John J. Gough</u>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		8 3		1 4 3 5 8		REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Thomas H. Kline					2a. DATE OF DEATH MONTH DAY YEAR May 8 1983			2b. HOUR 11 P M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 24, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Clevelandville, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Construction		
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Fairplay		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rfd. 1 Box 19 21733	
14. FATHER'S NAME FIRST MIDDLE LAST John C. Kline					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude A. Greenwalt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-18-2185		17. INFORMANT ADDRESS Mr. Ronnie L. Kline, Sharpsburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cadise Games</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute M.I.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 sec then 30 min</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5-4</u> 19 <u>83</u> to <u>5-8</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>5-8</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>W. R. Kline, M.D.</u>					DEGREE			22c. DATE SIGNED <u>5-8-83</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
					1931 Va. Ave. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-11-83		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park			23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash. Co., Md.		
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.					ADDRESS Boonsboro, Md. 21713		25a. DATE REC'D. BY REGISTRAR MAY 16 1983		25b. REGISTRAR'S SIGNATURE <u>W. R. Kline</u>	



Male	White	April 25, 1927	28
Livingston, St. B. A.			
Hagerston	Washington County Capital	Trick River	Washington
Maryland	Washington	Electricity	Box 19
John	Alma	Alma	Alma
No	215-10-2152	Mr. Charles L. Aling	Chapman, Md.

John H. Bond, Jr. Doonboro, Md. 21713  
2-11-55 Cedar Lawn Mem. Park  
Hagerston, Md. Co., Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR										
1 DECEASED NAME (TYPE OR PRINT) William Erman KREGLO					2a. DATE OF DEATH MONTH DAY YEAR May 21, 1983			2b. HOUR M		
3 SEX Male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR August 29, 1896		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7a. # UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 915 View Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY railroad		
13a. STATE Maryland					13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST William E. Kreglo, Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Schwinger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. I		17 INFORMANT Mrs. Doris E. Webb, Maugansville, Md.		ADDRESS				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the colon with liver metastases 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I (this hospital) attended the deceased from May 21, 1983, to May 21, 1983, that (I/we) lost saw the deceased alive on May 21, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (a) (we) (did) (did not) view the body (or bodies) prior death.										
22b. SIGNATURE [Signature]		22c. DATES SIGNED 5/23/83				22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature]				
22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE May 24, 1983		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland				
24 FUNERAL DIRECTOR MINNICH FUNERAL HOME NAME ADDRESS 415 E. Wilson Blvd., Hagerstown, Maryland 21740						25a. DATE RECD. BY REGISTRAR MAY 26 1983		25b. REGISTRAR'S SIGNATURE [Signature]		

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Standard Form No. 64

1/25/52



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND INTO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR OFFICE AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (1))  
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14360
1. DECEASED NAME (TYPE OR PRINT) <b>Jerry Wayne KUNKLEMAN</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MAY 2 1983		2b. HOUR <b>8:10</b> P M		
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 17, 1960</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>22</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>MAY 2 1983</b>		2d. HOUR <b>9:18</b> P M		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD				
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital DOA</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>guard</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>state</b>		
13a. STATE <b>Maryland</b> 13b. CITY <b>Washington</b> 13c. CITY OR TOWN <b>Hagerstown</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>323 Ridge Ave. 21740</b>										
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas B. Kunkleman Sr.</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dorothy E. Basore</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213-72-8388</b>		17. INFORMANT ADDRESS <b>Dorothy Kunkleman, Hagerstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>E 816 - MOTOR VEHICLE LOSING CONTROL AND OVERTURNING</b> <b>3170</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MOMENTS</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR AM MONTH DAY YEAR <b>8:05 P.M. MAY 2 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>LOST CONTROL HONDA ATC MOTORCYCLE AND VEHICLE OVERTURNED</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>OFF STREET</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>OFF CLAIR STREET, HAGERSTOWN, WASHINGTON, MD.</b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>Edward W. Ditto</i>			TITLE (SPECIFY) <b>DEPUTY</b> M.D.		MEDICAL EXAMINER <b>217 WEST WASHINGTON STREET</b>		DATE SIGNED <b>MAY 3, 1983</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>EDWARD W. DITTO, III, M.D.</b>			ADDRESS <b>HAGERSTOWN, MARYLAND 21740</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>			23b. DATE <b>May 5, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>			
24. FUNERAL DIRECTOR'S NAME <b>MINNICH FUNERAL HOME</b>					25a. DATE REC'D. BY REGISTRAR <b>MAY 9 1983</b> REGISTRAR'S SIGNATURE <i>John G. Calver</i>					
415 E. Wilson Blvd., Hagerstown, Md. 21740										



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 4 3 6 1 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 5/12/83			
1. DECEASED NAME FIRST MIDDLE LAST Josephine Langan				2b. HOUR 5:03 P.M.			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 12-10-1917		6. AGE (IN YEARS LAST BIRTHDAY) 65	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10. CITY OR TOWN OF DEATH Hagerstown, md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) heavy industry machinists		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE New Jersey		13b. COUNTY Monmouth		13c. CITY OR TOWN W. Reamsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Siarkowski		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Pulaski		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.	
17. INFORMANT Henry Siarkowski		ADDRESS Rt 10 Hagerstown, md.		13e. STREET ADDRESS 1 Maryann Court		Palme Ave 99999	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) CARDIAC ARREST				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCT.							
DUE TO, OR AS A CONSEQUENCE OF (c) ASCUHD							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost							
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert Gussweiler				DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT GUSSWEILER				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-16-83		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY Middletown New Jersey	
24. FUNERAL DIRECTOR (NAME) Gerald N. Minnich		ADDRESS 305 N. Topmac St. Hagerstown, md.		25a. DATE REC'D. BY REGISTRAR MAY 16 1983		25b. REGISTRAR'S SIGNATURE John J. Carney	



ACUTE MYOCARDIAL INFARCT  
CHRONIC MYOCARDIAL INFARCT

Not a true  
infarct

1/2  
1/4  
1/8

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
VR A15 ME (5)  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 4 3 6 2

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE RICHARD LEE</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MAY 6 1983			2b. HOUR 1:05 P.M.		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 14, 1897</b>	6. AGE (BY YEARS LAST BIRTHDAY) <b>85 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD <b>MAY 6 1983</b>	7d. HOUR 3:30 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b> MD		
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
13a. STATE <b>Virginia</b>		13b. CITY OR TOWN <b>Lexington</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS <b>Rt. 1, Box 28</b> 99999			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Richard Lee</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Marie Fisher</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-10-5236</b>		17. INFORMANT ADDRESS <b>Marie L. Houser, Rt. 1 B28, Lexington</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4292 IMMEDIATE CAUSE (a) #429 - ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>Virginia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ <b>10 - 15 YRS.</b>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>#250 - DIABETES MELLITUS</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Edward W. Ditto</i>		M.D. <b>DEPUTY</b>		TITLE (SPECIFY) <b>DEPUTY MEDICAL EXAMINER</b>		DATE SIGNED <b>MAY 6, 1983</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>EDWARD W. DITTO, III, M.D.</b>		ADDRESS <b>217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>May 9, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Falls Church, Virginia</b>		
24. FUNERAL DIRECTOR NAME <b>Money &amp; King Fun'l Hm.</b>				ADDRESS <b>171 W. Maple, Vienna, Va.</b>		25. DATE REC'D BY REGISTRAR <b>MAY 11 1983</b>		

John J. Lauer

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 4 3 6 3 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Glady M. Long</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>May 27 1983</i>			
3. SEX <i>F</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Aug. 22 1913</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Richard Alexander Marks</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lena Matilda Brooks</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>214-09-3366</i>		17. INFORMANT ADDRESS <i>Charles A. Long Same as #k3</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4960 Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bilateral pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>COPD</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>a</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost <i>saw</i> the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Abdul Latheed</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ABDUL LATHEED MD</i>				22e. ADDRESS <i>1600 OAK HILL AVE. HGT. MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5-31-83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill Cemetery Hagerstown Wash. Md.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <i>Gerald N. Minnich Hagerstown, Maryland</i>				25a. DATE REC'D. BY REGISTRAR <i>JUN 6 1983</i> REGISTRAR'S SIGNATURE <i>John J. Chief</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		83		14364		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Edward Leroy Miller				2a. DATE OF DEATH MONTH DAY YEAR May 17 1983		2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 15 1915		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. #9 Box 375 Beaver Creek				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales		12b. KIND OF BUSINESS OR INDUSTRY Investments	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST William H. Miller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Winters					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 177-01-3688		17. INFORMANT ADDRESS Vivian E. Miller Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>probable Ventricular Tachycardia</u> 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>yes</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>12-19</u> , 19 <u>77</u> , to <u>5-17</u> , 19 <u>83</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>3-7</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.									
22b. SIGNATURE <u>James A. [Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>5-18-83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-20-83		23c. NAME OF CEMETERY OR CREMATORY Beaver Creek Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Beaver Creek Wash. Md.			
24. FUNERAL DIRECTOR NAME Gerald N. Minnich Hagerstown, Maryland				25a. DATE REC'D. BY REGISTRAR MAY 23 1983					

20% COTTON



General A. Stanton, Baltimore, Maryland  
705 N. E. Avenue, Baltimore, Md.  
March 10, 1911

Dear Mr. Stanton:  
I have the honor to acknowledge the receipt of your letter of the 10th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8314365 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Grayson Horine Miller						2a. DATE OF DEATH MONTH DAY YEAR May 16, 1983				2b. HOUR 9:30A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 7, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Frostown, Md.		7b. CITIZEN OF WHAT COUNTRY? (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WESTERN MARYLAND CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Forrest Ranger		12b. KIND OF BUSINESS OR INDUSTRY Dept of Park			
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Middletown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rfd. 1		21769	
14. FATHER'S NAME FIRST MIDDLE LAST Charles E. Miller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Blanche Horine							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-I4-5743		17. INFORMANT ADDRESS Mrs. Patsy L. Stanley, Rfd. 1 Middletown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure.</u> 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive pulmonary disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Many years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Adenocarcinoma of the colon with metastases.</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (X) (this hospital) attended the deceased from <u>October 3,</u> 19 <u>79</u> , to <u>May 16,</u> 19 <u>83</u> , that (I) (X) last saw the deceased alive on <u>May 16,</u> 19 <u>83</u> , and that in (my) (XX) opinion death occurred on the date and hour and from the causes stated above, (I) (XX) (did) (XXX) view the body after death.											
22b. SIGNATURE <u>Fe U. Porciuncula</u>				DEGREE <u>M.D.</u> 22c. DATE SIGNED <u>May 16, 1983</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fe U. Porciuncula, M. D.				22e. ADDRESS P. O. Box 2007 1500 Pa. Ave., Hagerstown, MD 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-19-83		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Boonsboro, Wash. Co. Md.			
24. FUNERAL DIRECTOR John H. Bast, Jr. Boonsboro, Maryland						25a. DATE REC'D. BY REGISTRAR MAY 20 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>			

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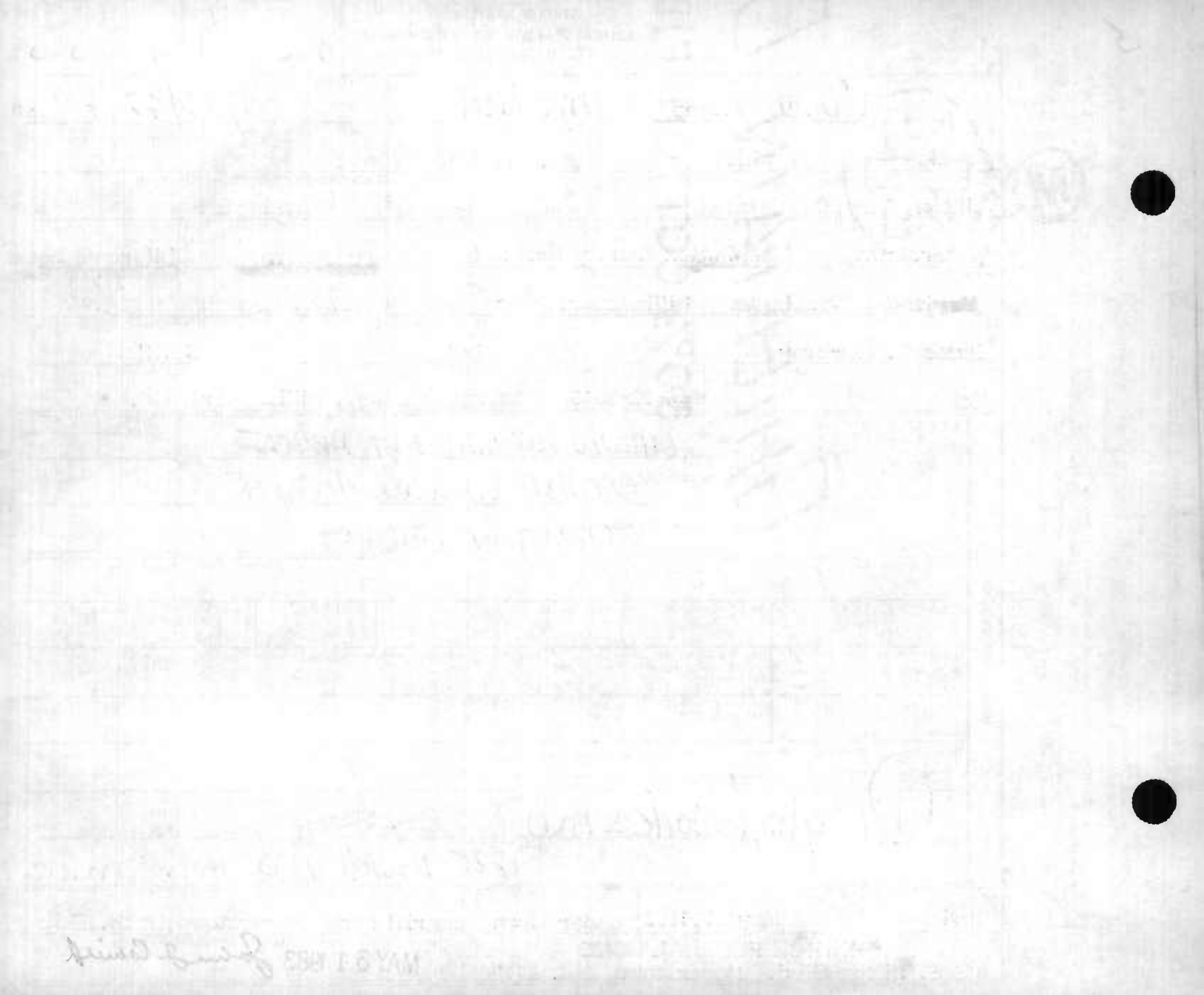
Handwritten text, mostly illegible due to fading and bleed-through. Some words like "DATE" and "BY" are faintly visible.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 shall be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or other authorized person must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) <i>Conise Anna Mitchell</i>					2a. DATE OF DEATH MONTH <i>5/23/83</i> YEAR <i>83</i> 2b. HOUR <i>4:00</i> PM				
3 SEX <i>female</i>		4 RACE <i>white</i>		5 DATE OF BIRTH MONTH <i>Nov. 27,</i> DAY <i>1910</i> YEAR		6 AGE (IN YEARS LAST BIRTHDAY) <i>72</i> YRS.		7 UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Elkton, Virginia</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.			
10 CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housemother</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Children's Home</i>	
13a STATE <i>Maryland</i>		13b COUNTY <i>Washington</i>		13c CITY OR TOWN <i>Williamsport</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>117 N. Conococheague St.</i> 21795	
14. FATHER'S NAME FIRST <i>James C.</i> MIDDLE <i>Mowbray</i> LAST					15. MOTHER'S MAIDEN NAME FIRST <i>Lula</i> MIDDLE <i>Shifflett</i> LAST				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. <i>214-32-2615</i>		17 INFORMANT ADDRESS <i>Nancy Banzhoff, Williamsport, Md.</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO RESPIRATORY ARREST</i> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <i>CEREBRAL VASCULAR ACCIDENT.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>RESPIRATORY FAILURE</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>C. Wright Wooster MD</i> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS <i>1825 Howell Road Hagerstown, Md</i>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>May 27, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Lawn Memorial Park</i>		23d. LOCATION CITY OR TOWN <i>Hagerstown</i> COUNTY <i>Wash.</i> STATE <i>Md.</i>			
24. FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i>				25a. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE) <i>MAY 31 1983 John J. Lamm</i>					
415 E. Wilson Blvd., Hagerstown, Md. 21740									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

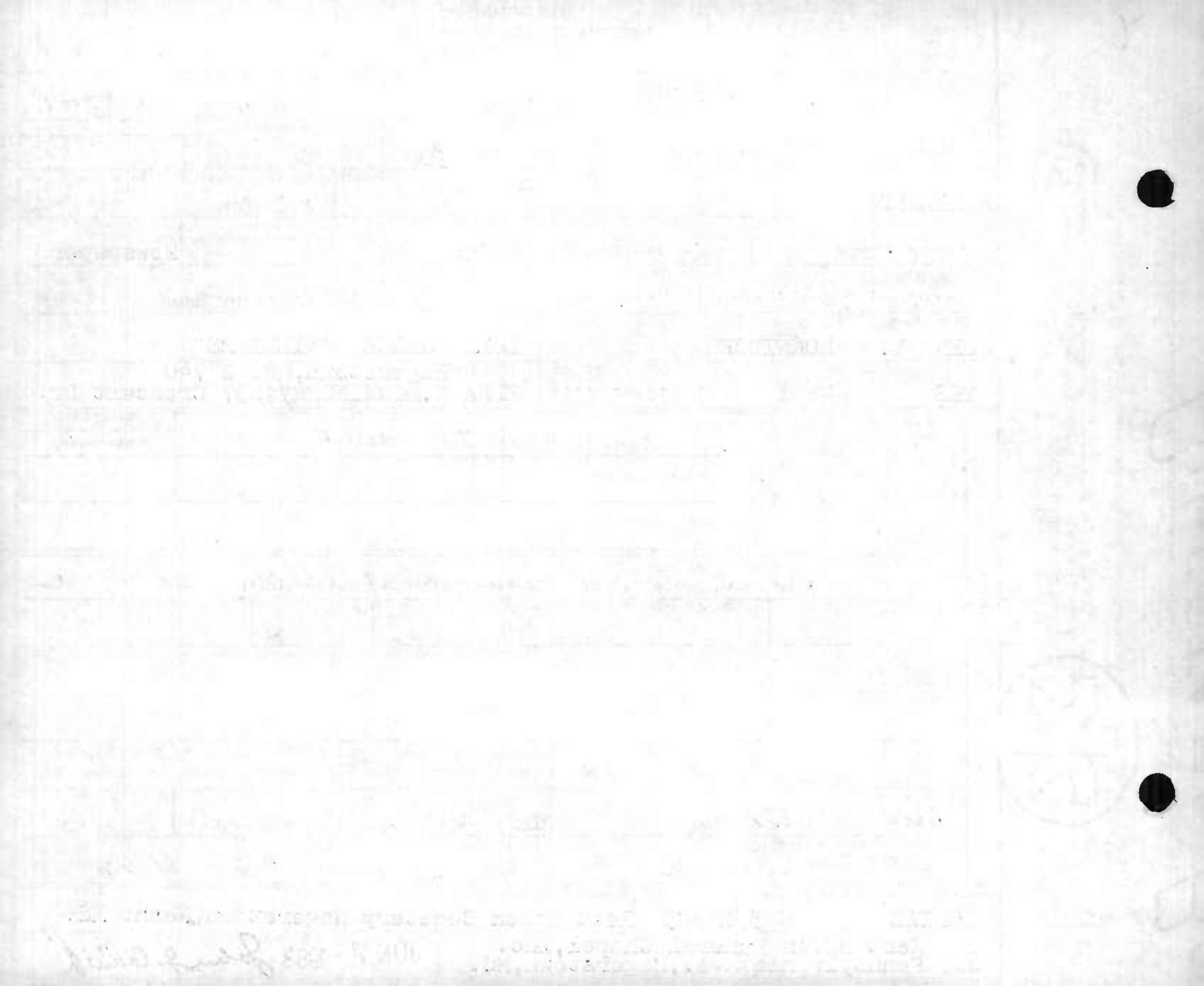
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 3 1 4 3 6 7 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harry Raymond Monninger		2a. DATE OF DEATH MONTH DAY YEAR May 18 1983		2b. HOUR 8:00 P.M.	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 05 23 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Newspaper		12b. KIND OF BUSINESS OR INDUSTRY Newspaper	
13a. STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 237 Crescent Road 21740	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN W. MONNINGER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LULA GRACE "WILLIAMS"			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I 214-09-7465		17. INFORMANT Hagerstown, Md. 21740 EDNA M. MONNINGER 21237 Crescent Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardio respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Transitional Cell carcinoma of bladder - advanced					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Feb 8, 1972, to May 18, 1983, that (we) lost saw the deceased alive on May 18, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Harold R. Titch Jr.		DEGREE MD		22c. DATE SIGNED 5-20-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. R. TRITCH JR.		22e. ADDRESS HAGERSTOWN, Md 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/21/83		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery Hagerstown, Wash. Md.	
23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Md.		25a. DATE REC'D. BY REGISTRAR JUN 7 1983			
24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc. 1601 Pennsylvania Ave., Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE John J. Canfield			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified by doctor.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 3 1 4 3 6 8 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Alma Ruth Moore								May 29 1983		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		Jan. 22 1894		89 YRS.		MONTHS DAYS		HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Washington County MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		252 S. Potomac Street						Homemaker		Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		21740	
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		252 S. Potomac Street			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
Thomas Hamilton Mc Carter				Elanore Fridinger							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
No				214-09-8332A				Helen J. Moore Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> 5070 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>Arteriosclerosis, C.O.B., Undermining, C.O.B., Osteoarthritis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (1) (the <del>XXXX</del> ) attended the deceased from <u>25 Sept.</u> , 19 <u>63</u> , to <u>date</u> , 19 <u>83</u> , that (1) <del>XX</del> lost <u>so</u> the deceased alive on <u>29 May</u> , 19 <u>83</u> , and that in (my) <del>XX</del> opinion death occurred on the date and hour and from the causes stated above. (1) (XX) did <del>XXXX</del> view the body after death.											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
<u>Richard T. Binford</u>		M.D.		31 May, 1983							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Richard T. Binford, M.D.		1135 Potomac Ave., Hagerstown, Md. 21740									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		6-1-83		Rose Hill Cemetery		Hagerstown Wash. Md.					
24. FUNERAL DIRECTOR NAME		305 N. Potomac Street		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Gerald N. Minnich		Hagerstown, Maryland		JUN 6 1983		<u>John J. Linnick</u>					

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705 E. Holman Street

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 4 3 6 9 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Barbara Ann Morgan</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>5-11-83</b>			2b. HOUR <b>6:35 AM</b>			
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 1, 1933</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Williamsport</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>21795 29 Hampton Road, East</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William L. Hankey</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Evelyn L. Noel</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Donald Morgan, Williamsport, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) Cardio-respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b> <b>hours</b> <b>years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>July 19 81</b> to <b>May 11 19 83</b> , that (I) (we) lost saw the deceased alive on <b>May 11 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)											
22b. SIGNATURE <b>W S Hood MD</b>					DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5-11-83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W S Hood</b>					22e. ADDRESS <b>Hagerstown Md</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>			23b. DATE <b>May 14, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</b>					25a. DATE REC'D. BY REGISTRAR <b>MAY 13 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

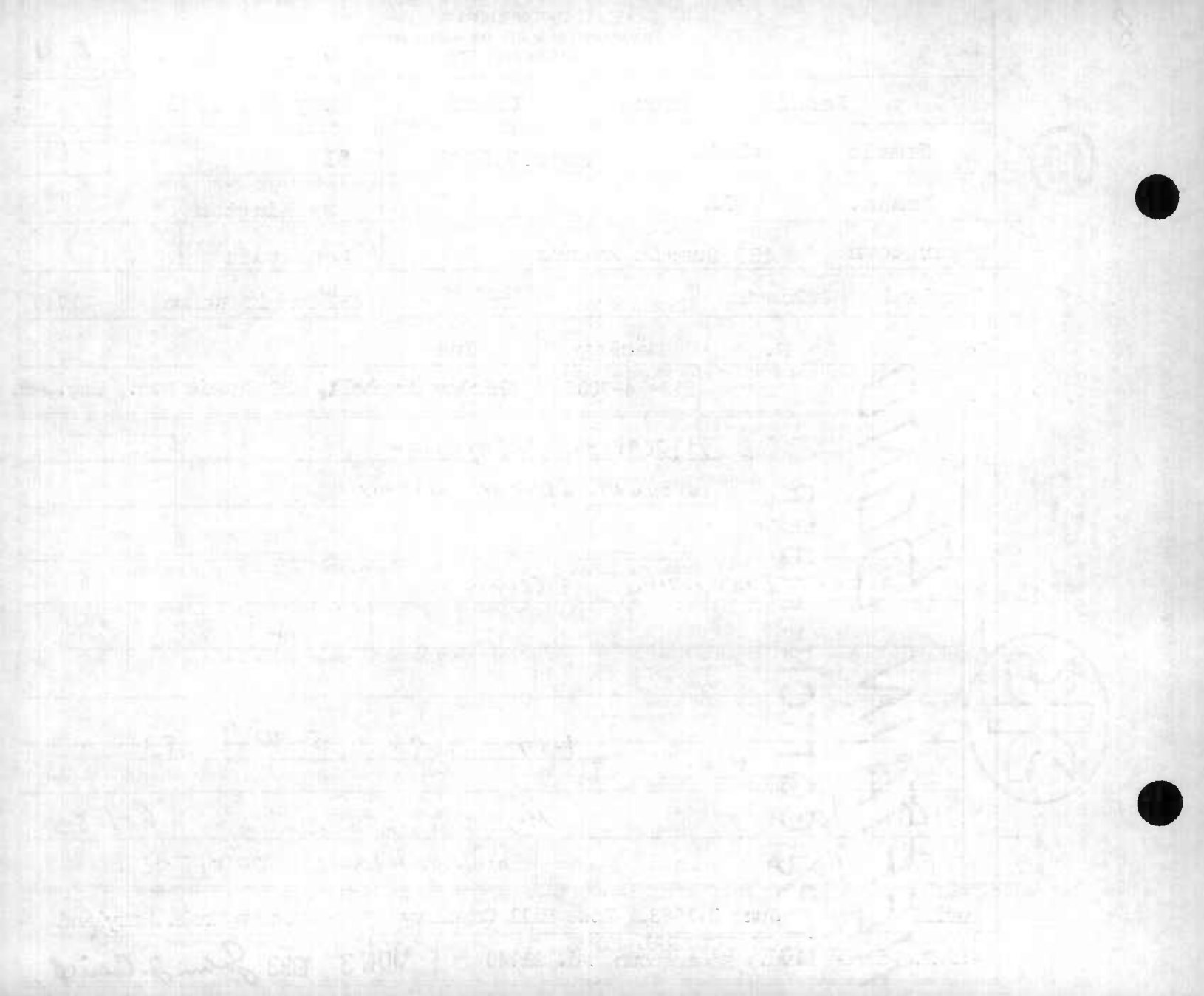
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		83 14370 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Bessie Irene MUNDEY					2a. DATE OF DEATH MONTH DAY YEAR May 31, 1983			2b. HOUR M	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Sept. 7, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 439 Summit Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS, 439 Summit Avenue 21740		
14. FATHER'S NAME FIRST MIDDLE LAST John H. Macclay					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sue				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 219-14-9808		17. INFORMANT ADDRESS Shirley Campbell, 439 Summit Ave., Hag., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a Chronic Idiopathic Edema									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1-17, 1983, to 5-30, 1983, that (I) (we) last saw the deceased alive on 5-5, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ali Pop				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6-1-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eli Roza				22e. ADDRESS WASHINGTON COUNTY HOSPITAL.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE June 2, 1983		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland			
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a. DATE REC'D. BY REGISTRAR JUN 3 1983		25b. REGISTRAR'S SIGNATURE John J. Conner			



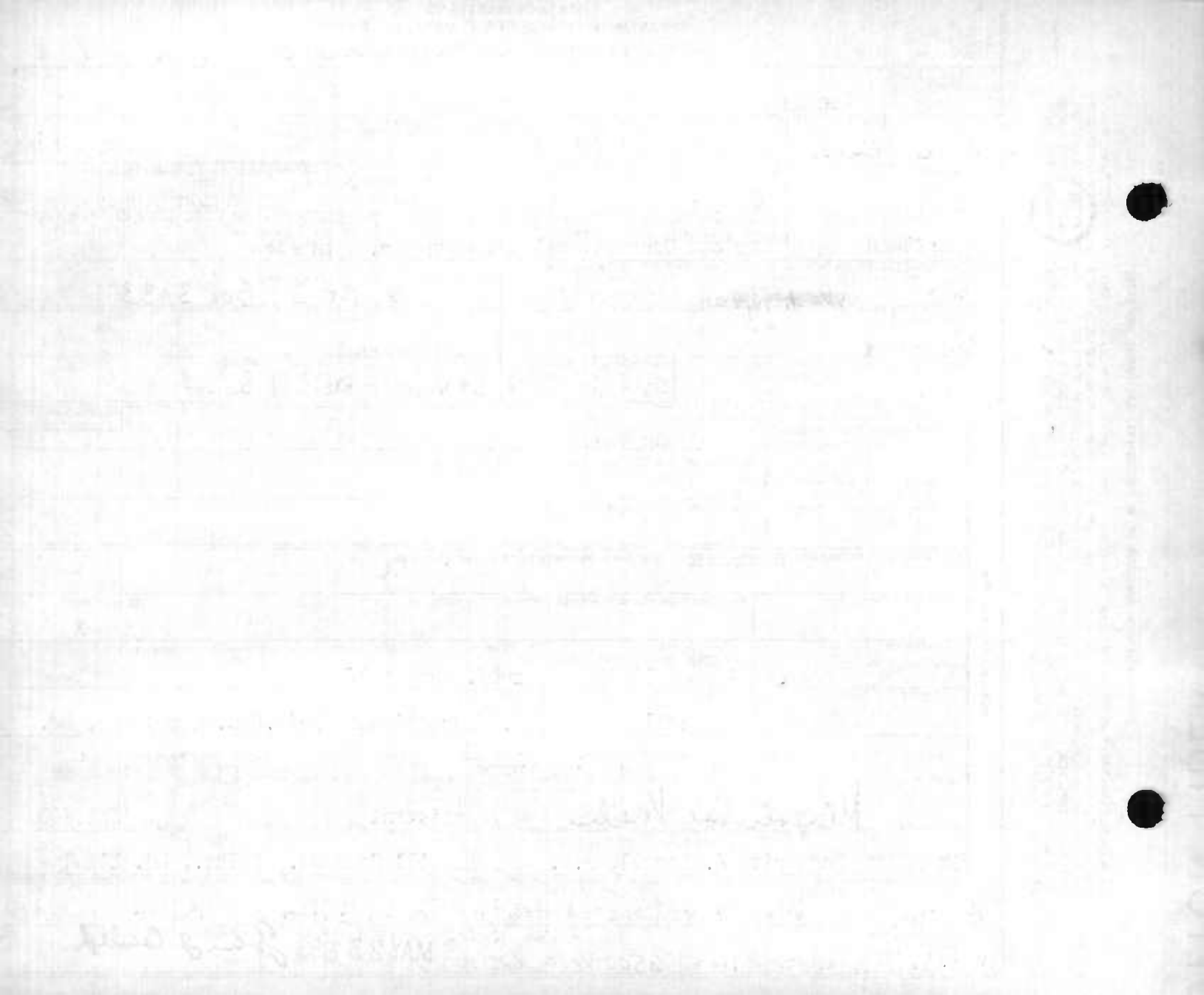


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH														REG. NO.	14371
1. DECEASED NAME (TYPE OR PRINT) <b>Benone Munteanu</b>														2a. DATE OF DEATH	2b. HOUR
3. SEX <b>Male</b> 4. RACE <b>Caus.</b> 5. DATE OF BIRTH <b>3 28 56</b> 6. AGE (IN YEARS) <b>27</b> YRS. 7. IF UNDER 1 YR. 8. IF UNDER 24 HRS.														2c. DATE PRONOUNCED DEAD	2d. HOUR
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Romania</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>														9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland Correctional Training Cen.</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mason</b> 12b. KIND OF BUSINESS OR INDUSTRY															
13a. STATE <b>MD</b> 13b. COUNTY <b>Washington</b> 13c. CITY OR TOWN <b>Hagerstown</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>Rt. 3, Box 3333</b>															
14. FATHER'S NAME <b>Unknown</b> 15. MOTHER'S MAIDEN NAME <b>Unknown</b>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> 16b. SOCIAL SECURITY NO. <b>062-62-5328</b> 17. INFORMANT ADDRESS <b>St. Vincent DePaul Society</b>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hanging</b> <b>9530</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>7:00 P.M. 5/14/83</b> 21b. TIME OF INJURY <b>7:00 P.M. 5/14/83</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subj. hung self</b>															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>cell</b> 21f. LOCATION (STREET, CITY OR TOWN, COUNTY, STATE) <b>Md. Correctional Train. Cen. Hagerstown, Md.</b>															
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE <b>Margarita A. Korell</b> M.D. <b>Assistant</b> MEDICAL EXAMINER DATE SIGNED <b>5/16/83</b>															
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b> ADDRESS <b>111 Penn St., Balto., Md. 21201</b>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>May 19, 1983</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b> 23d. LOCATION (CITY OR TOWN, COUNTY, STATE) <b>Balto., Balto., MD</b>															
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home</b> ADDRESS <b>Balto. 21212 6500 York Rd.</b> 25a. DATE REC'D. BY REGISTRAR <b>MAY 23 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					83 14372				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas Grant Myers					2a. DATE OF DEATH MONTH DAY YEAR 5/12/83			2b. HOUR 12:10 PM	
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 4/19/26		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Big Pool		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Residence				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Electrician/Railroad		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Wash.		13c. CITY OR TOWN Big Pool		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 1, Box 9 21711	
14. FATHER'S NAME FIRST MIDDLE LAST Roy P. Myers				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nealie Kathryn Thomas					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II				16b. SOCIAL SECURITY NO. 220-16-2148		17. INFORMANT ADDRESS Mrs. Betty L. Myers Big Pool Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <u>carcinoma of the Lung with widespread metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Smoking</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 23 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>(do not)</u> attended the deceased from <u>June 4, 1981</u> , to <u>present</u> , 19 <u>82</u> , that (I) <u>lost</u> saw the deceased alive on <u>August 18, 1982</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(do)</u> (did not) view the body after death.									
22b. SIGNATURE <u>Mary E. Money MD</u>					DEGREE M.D.			22c. DATE SIGNED 5/13/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mary E. Money, M.D.					22e. ADDRESS 1708 Oak Hill Avenue Hagerstown, MD 21740				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 14, 83		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Park		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Md			
24. FUNERAL DIRECTOR <u>Donald E. Thompson</u> Thompson Funeral Home Clearspring Md.					25a. DATE REC'D. BY REGISTRAR OF REGISTRAR'S SIGNATURE MAY 16 1983 <u>John J. Carver</u>				

RECEIVED  
JAN 1 1961



*(Signature)*

MAILED 1 JAN 1 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the health officer. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Leila Mary NEIKIRK		2a. DATE OF DEATH MONTH DAY YEAR April 20, 1983		2b. HOUR 5:00A M	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR October 25, 1880		6. AGE [IN YEARS (LAST BIRTHDAY)] 102 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Williamsport		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 51 Tammany Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Funkstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Renner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca		13e. STREET ADDRESS 44 W. Baltimore Street 21734			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Barbara Ingram Groh, Williamsport, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) ARTEROSCLEROTIC CARDIOVASCULAR DISEASE 25-30 YRS DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-31-71 to 4-19 1983, that (I) (we) last saw the deceased alive on APRIL 19 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)							
22b. SIGNATURE Edward W. Ditto		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Apr. 20, 1983			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. DITTO 111MD		22e. ADDRESS 217 W. WASHINGTON ST. HAGERSTOWN, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Apr. 23, 1983		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a. DATE REC'D. BY REGISTRAR APR 25 1983			
				25b. REGISTRAR'S SIGNATURE John J. Carver			

BP



100000

AT THE OFFICE OF THE DIRECTOR OF THE BUREAU OF THE CENSUS

REPORT NO. 100000



U.S. DEPARTMENT OF COMMERCE

WASHINGTON, D.C.

U.S. DEPARTMENT OF COMMERCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

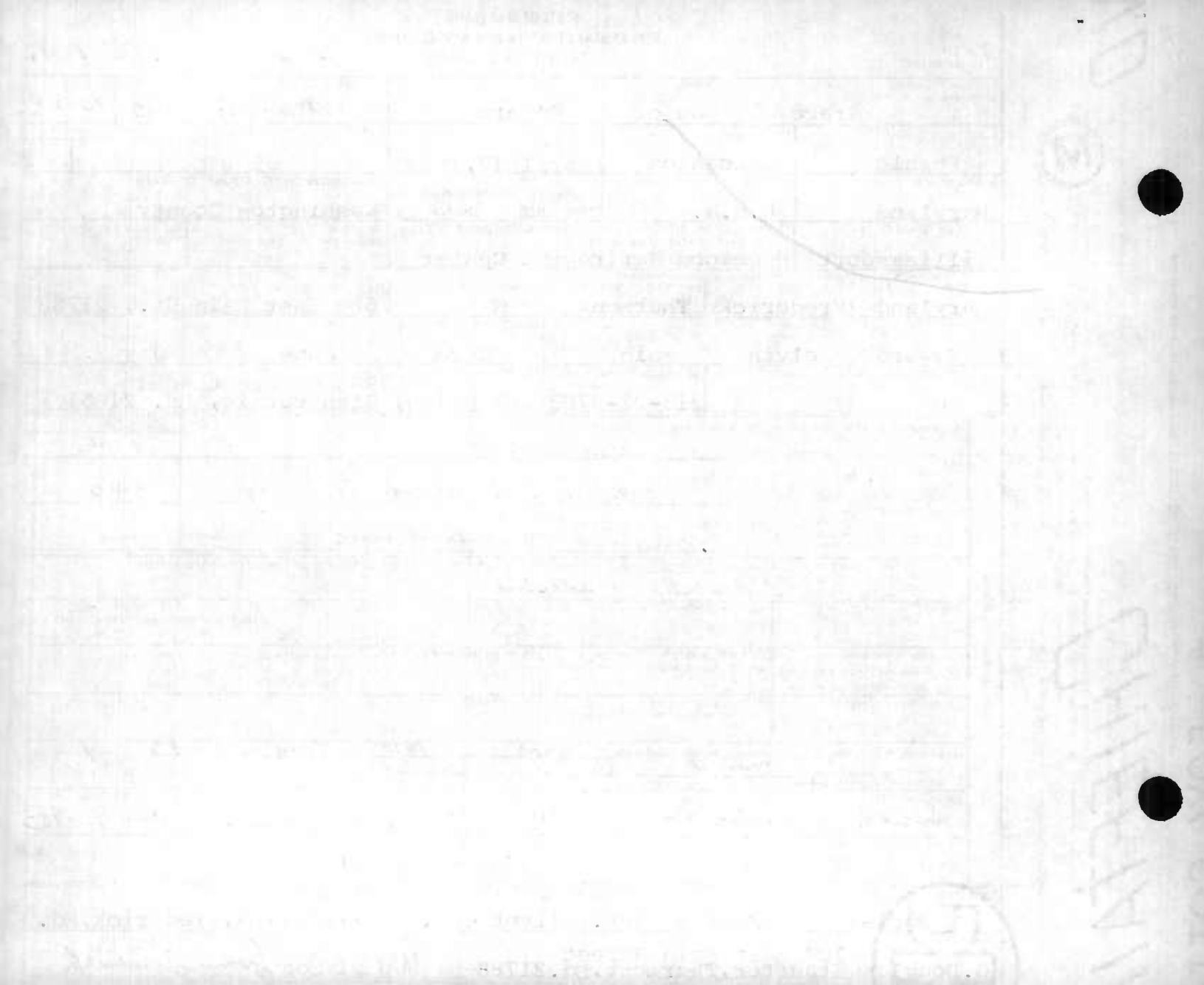
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers: Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be conducted.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 14374			
1. DECEASED NAME (TYPE OR PRINT) Grace Maude O'Haro				2a. DATE OF DEATH MONTH DAY YEAR May 18 1983			
3. SEX Female				4. RACE Caucasion		5. DATE OF BIRTH MONTH DAY YEAR April 17, 1888	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		2b. HOUR 1005 P M	
10. CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Homewood Retirement Center		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Thurmont		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Melvin Main				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Jane Joy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-22-3703		17. INFORMANT ADDRESS 7983 Nolcrest Road Joy Hnida, Glen Burnie, Md. 21061			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4439 IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>gangrene of distal left leg</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>peripheral vascular disease</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 3 mo yes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>diabetes mellitus</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>1978</u> to <u>May 18</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>May 18</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, if (we) (did) (and not) view the body after death.							
22b. SIGNATURE <u>Harold R. Tritch Jr</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>May 18 1983</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>H.R. TRITCH</u>				22e. ADDRESS <u>HAGERSTOWN, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>5/23/83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Frederick, Frederick, Md.</u>	
24. FUNERAL DIRECTOR NAME <u>G. Douglas Stauffer, Thurmont, Md. 21788</u>				25a. DATE REC'D. BY REGISTRAR <u>MAY 26 1983</u>			
				25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>			

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 212-1234.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					83 14375 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Walter Herman Palmer					2a. DATE OF DEATH MONTH DAY YEAR May 25, 1983			2b. HOUR 12:00 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 11, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cutter		12b. KIND OF BUSINESS OR INDUSTRY Leather	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Smithsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route # 4 Box # 23	
14. FATHER'S NAME FIRST MIDDLE LAST William Henry Palmer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Miller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-09-5121		17. INFORMANT ADDRESS E. Virginia Wilson (item 13 above)					
18. CAUSE OF DEATH (Enter only one cause per line for line 1 and 1c) PART I. DEATH WAS CAUSED BY: 5938 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured aortic aneurysm (c) DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. Is part of death									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2-8, 1977, to 5-25, 1985, that (I) (we) last saw the deceased alive on 5-25-85, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature] DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-25-85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. R. Ladd 124612				22e. ADDRESS 382 John Street, Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 27, 1983		23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Williamsport Washington Maryland			
24. FUNERAL DIRECTOR NAME Major M. Osborne P.O. Bx # 348 Williamsport, MD				24b. ADDRESS 21795		25a. DATE REC'D. BY REGISTRAR MAY 31 1983			
25b. REGISTRAR'S SIGNATURE [Signature]									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8314376		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Charlotte Arlene PAULSGROVE				2a. DATE OF DEATH MONTH DAY YEAR May 24, 1983		2b. HOUR 8:45 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 25, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Beaver Creek, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rfd. 9 Box 313				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Grocery Store	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rfd. 9 Box 313	
14. FATHER'S NAME FIRST MIDDLE LAST G. Albert McKee				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Jacobs					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 217-18-7696		17. INFORMANT ADDRESS Mr. Donald W. Paulsgrove, Rfd. 9 Box 313 Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Adeno Carcinoma Lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 Mos.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Nov 7, 1983, to May 24, 1983, that (I) (we) lost saw the deceased alive on May 20, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edward W. DiA... (M.D.)				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 25, 1983			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward W. DiA... (M.D.)				22e. ADDRESS 217 W. Washington St. Hagerstown, Md 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-27-83		23c. NAME OF CEMETERY OR CREMATORY Beaver Creek Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Beaver Creek, Wash, Co Md			
24. FUNERAL DIRECTOR NAME John H. Bast, Jr. Boonsboro, Md. 21713				25a. DATE REC'D. BY REGISTRAR MAY 31 1983		25b. REGISTRAR'S SIGNATURE John J. Baker			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8314377 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			2b. HOUR	
William Branch PERKINSON					May 25 1983			5:35am	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR	
Male		White		November 7, 1909		73 YRS		MONTHS DAYS HOURS MIN	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		USA				WASHINGTON MD.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
HAGERSTOWN		WESTERN MARYLAND CENTER				Laborer		None	
13a. STATE					13b. CITY OR TOWN		13c. STREET ADDRESS		
Maryland					Anne Arundel Severn		Unknown 21144		
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME				
Ozzie PERKINSON					Susie KEMP				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS		
No					231-05-2835A		William Perkinson Linden, Tenn. 37096		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
4960 IMMEDIATE CAUSE (a) Respiratory failure									24 hours
DUE TO, OR AS A CONSEQUENCE OF									
Pneumonia									24 hours
DUE TO, OR AS A CONSEQUENCE OF									
Chronic obstructive pulmonary disease									years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
Arteriosclerotic heart disease; cerebrovascular accident									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from 8-3-82, 19, to 5-3-83, 19, that (I) (X) lost									
saw the deceased alive on 5-25-83, 19, and that in (my) (X) opinion death occurred on the date and hour and from the causes stated above, (I) (X) (did) (X) view the body after death.									
22b. SIGNATURE Fe U. Porciuncula					DEGREE M.D.			22c. DATE SIGNED 5-25-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fe U. Porciuncula, M.D.					22e. ADDRESS WESTERN MARYLAND CENTER, HAGERSTOWN, MARYLAND 21740				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Removal-Burial					Dean Cemetery		Linden, Perry, Tennessee		
24. PRINTED NAME OF FUNERAL HOME Robert E. Dailey & Son					1201 N. Market St. Frederick, Maryland		25a. DATE REC'D. BY REGISTRAR JUN 8 1983		
Funeral Homes - P. 2					25b. REGISTRAR'S SIGNATURE John J. Canale				

MEDICAL CERTIFICATION

8 1

8-3-8

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 3 1 4 3 7 8 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>ERAST Harold PETERSON</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 6 83</b>		2b. HOUR <b>11-AM</b>	
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 23, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>contract painter</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert G. Peterson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Matty Lovell</b>		13e. STREET ADDRESS <b>Lehman Mill Rd. Rt. 8</b> 21740	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Marines</b>		17. INFORMANT ADDRESS <b>Elizabeth Shilling, Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR ARREST</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of the Bronchus - Met</b> (c) <b>Bilateral Bronchopneumonia</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 6</b> , 19 <b>83</b> , to <b>MAY 6</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>MAY 6</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Timothy C. Breyer MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>MAY 6 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Timothy C. Breyer MD</b>		22e. ADDRESS <b>Washington County Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>May 9, 1983</b>		23c. LOCATION NAME OF CEMETERY OR CREMATORY <b>Green Lawn Mem. Park</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Williamsport, Wash., Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 11 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>	
415 E. Wilson Blvd., Hagerstown, Md. 21740					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		83 14379 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>John Wilson Price</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>May 29, 1983</b>				2b. HOUR <b>M</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 23, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>farmer (retired)</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Route 1, Mt. Aetna Rd. 21740</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Henry Price</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Betty Blanche Carrier</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>W.W.I 220-34-0943</b>		17. INFORMANT ADDRESS <b>Doris P. Krouse, Hagerstown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>Coronary anast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>years</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10-15 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5-28-1983</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>5-27-1983</b> to <b>5-29-1983</b> , that (I) <del>we</del> last saw the deceased alive on <b>5-28-1983</b> , and that in <del>my</del> <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> <del>did not</del> view the body after death.									
22b. SIGNATURE <b>John J. Carrier</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>5-25-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH SECONDARI</b>				22e. ADDRESS <b>BOONS BORO 21713</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>June 1, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 3 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carrier</b>			
415 E. Wilson Blvd., Hagerstown, Md. 21740									

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U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

John H. ...  
...



...

...

June 3, 1908  
J. H. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 83 14380			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Donald R. Pruitt</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>5-11-83</b>		2b. HOUR <b>2:53P</b>			
3 SEX <b>male</b>		4 RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 15 46</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>36</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS <b>YRS.</b>		8. IF UNDER 1 YEAR MONTHS DAYS HOURS <b>YRS.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Nebraska</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.							
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WESTERN MARYLAND CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Navy Dept.</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Hillcrest Heights</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <b>3907 25th Ave. 20748</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Pruitt</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Fern Taylor</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>507-64-0284</b>		17. INFORMANT ADDRESS <b>Patty Pruitt same as item 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4300 IMMEDIATE CAUSE (a) Cardiorespiratory arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ruptured intracranial aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Phin</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>hypertension, seizure, recurrent infections</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (X) (this hospital) attended the deceased from <b>3/24</b> , 19 <b>83</b> , to <b>5/11</b> , 19 <b>83</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the cause stated above. (If not (did) (do not) view the body after death.													
22b. SIGNATURE <b>Horacio P. Palomo</b>		DEGREE		22c. DATE SIGNED <b>5/11/83</b>				22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Horacio P. Palomo</b>		22f. ADDRESS <b>1500 Penn-Care Hagerstown</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5/16/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Blue Springs Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Blue Springs Gage Nebraska</b>							
24. FUNERAL DIRECTOR NAME ADDRESS <b>G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.</b>						25a. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE <b>MAY 17 1983 John J. Connel</b>							

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 4 3 8 1 REG. NO.
1. DECEASED NAME (TYPE OR PRINT) Richard Myers Rhodes			2a. DATE OF DEATH MONTH DAY YEAR 5 3 83	
3. SEX male		4. RACE white	2b. HOUR 2 15 AM	
5. DATE OF BIRTH MONTH DAY YEAR Jan. 6, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		10. CITY OR TOWN OF DEATH Hagerstown		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) engineer		
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS 106 West Side Avenue 21734		
13b. STATE Maryland		13c. CITY OR TOWN Funkstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Clinton Rhodes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Roberta Myers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 705-10-6766		17. INFORMANT ADDRESS Emma Rhodes, Funkstown, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Refractory Ventricular Tachycardia DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Approximate Interval Between Onset and Death hours yes				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Recent Cerebral embolus, Diabetes mellitus				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 5-2, 19 83, to 5-3, 19 83, that (I) (we) last saw the deceased alive on 5-2, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE J. J. J. J.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-3-83
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE May 6, 1983		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park
23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland		24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740		
25a. DATE REC'D. BY REGISTRAR MAY 6 1983		25b. REGISTRAR'S SIGNATURE John J. J. J.		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last SAMUEL HENRY RUCK, JR.			2a. DATE OF DEATH Month Day Year MAY 16, 1983			2b. HOUR 10:50 A M					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH OCT. 4, 1924		6. AGE (In years last birthday) 58 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON Md.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hos		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Metal		12b. KIND OF BUSINESS OR INDUSTRY Pipe Organ					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 21722 Rt # 1, Box 298					
14. FATHER'S NAME First Middle Last SAMUEL H. RUCK, SR.			15. MOTHER'S MAIDEN NAME First Middle Last LAURA VA. "HARTER"								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) WW II		17. INFORMANT Address Laurette S. Ruck/Rt#5, Box 34, Hag. Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Disseminated Intravascular coagulation and</u> <u>2866</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemorrhagic Diathesis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) <del>this hospital</del> attended the deceased from <u>APRIL 20, 1983</u> , to <u>MAY 16, 1983</u> , that (I) <del>(we)</del> saw the deceased alive on <u>MAY 16, 1983</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.											
22b. SIGNATURE <u>Edward W. Ditto</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED MAY 17, 1983				
22d. PHYSICIAN'S NAME (Type) EDWARD W. DITTO, III, M.D.					22e. ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740						
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE 5/19/83		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			23d. LOCATION (City or Town) (County) (State) Hagerstown, Wash., Md.				
24. FUNERAL DIRECTOR Rest Haven Funeral Chapel, Inc. 1601 Pennsylvania Ave./Hagerstown, Md.					25a. REC'D BY REGISTRAR DATE MAY 23 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner will be notified or requested.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 3 1 4 3 8 3

1. DECEASED NAME (TYPE OR PRINT) <b>John J. Saunders</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>May 10, 1983</b>			2b. HOUR <b>M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 6 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>147 Belview Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Service Mngr. Goodyear</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>147 Belview Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles William Saunders</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lola Isabel Cowden</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT <b>Irene Lorenze</b>		17. ADDRESS <b>119 N. Litmoor Ter. Silver Spng, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction 1 day</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary artery disease years</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis 11 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Hypertensive Cardiovascular Disease</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <del>XXXXXX</del> attended the deceased from <b>20 December 19 71</b> to <b>late</b> 19 <b>83</b> , that (I) <del>was</del> <b>not</b> view the deceased alive on <b>27 April</b> <b>83</b> , and that in (my) <del>own</del> <b>own</b> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> <b>did</b> view the body after death.									
22b. SIGNATURE <b>Richard T. Binford</b> DEGREE						22c. DATE SIGNED <b>11 May, 1983</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard T. Binford, M.D.</b>						22e. ADDRESS <b>1135 Potomac Avenue, Hagerstown, Md. 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-13-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery Clearspring Wash. Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Gerald N. Minnich</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 16 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8314384	
1. DECEASED NAME (TYPE OR PRINT) Frank Leo SCHWEDA			2a. DATE OF DEATH MONTH DAY YEAR May 30, 1983		2b. HOUR II:30 PM	
1. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 31, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chicago, Ill.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD		
10. CITY OR TOWN OF DEATH Keedysville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rfd. I Box 27I- AI		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Improvement Industry		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b. COUNTY Washington	13c. CITY OR TOWN Keedysville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Leo Schweda			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aglene Yamite			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1949- 1960 329-24-3057		17. INFORMANT ADDRESS Rfd. I Box 27I-AI Mrs. Karyle A. Schweda, Keedysville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> 1519 DUE TO, OR AS A CONSEQUENCE OF (b) <u>extensive gastric carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>with hepatic metastases</u> 3 mo						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1982</u> , 19 <u>82</u> , to <u>5/30</u> , 19 <u>83</u> that (I) (we) last saw the deceased alive on <u>5/2</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>[Signature]</u> DEGREE				22c. DATE SIGNED <u>5/31/83</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>D G Trausch</u>
22e. ADDRESS <u>4 West Street</u>				23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal-Burial		
23b. DATE 6-I-83		23c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chicago, Cook Co. Ill.		
24. FUNERAL DIRECTOR NAME John H. Bast, Jr. Boonsboro, Md. 21713 ADDRESS				25. DATE REC'D BY REGISTRAR JUN 6 1983 REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										3	REG. NO.	4	3	8	5		
1. FOR STATE REGISTRAR																	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RICHARD E. SEASE Jr.										2b. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 11:30 A M MAY 9 1983							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 5, 1965		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 17		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 11:30 A M MAY 9 1983							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.					
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Penna.										13b. CITY OR TOWN Franklin		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS Box 326		99999	
14. FATHER'S NAME FIRST MIDDLE LAST Richard E. Sease Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phyllis Jean Toms												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 195-54-0718					17. INFORMANT ADDRESS Mrs. Phyllis Ebersole Box 326 Rouzerville, Penna.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>8121</u> E-812 - MOTOR VEHICLE/MOTOR VEHICLE COLLISION DUE TO, OR AS A CONSEQUENCE OF (b) <u>(MASSIVE BRAIN STEM INJURY)</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH APPROX. 36 HOURS							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR 11:10 P.M. MAY 7 1983				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) OCCUPANT OF REAR SEAT; IN REAR END COLLISION WITH PICKUP TRUCK									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) ROUTE #16				21f. LOCATION 1/2 MILE WEST OF RT. #16, WAYNESBORO CITY LIMITS, FRANKLIN, PA.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE Edward W. Ditto				TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER				DATE SIGNED MAY 9, 1983									
EXAMINER'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.				ADDRESS HAGERSTOWN, MARYLAND 21740													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/11/83		23c. NAME OF CEMETERY OR CREMATORY Harbaugh Church Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Washington Top Franklin Pa.							
24. FUNERAL DIRECTOR David L. Cross				ADDRESS 50 S. Broad St. Waynesboro, Pa. 17268				25a. DATE REC'D. BY REGISTRAR MAY 16 1983				25b. REGISTRAR'S SIGNATURE Joan J. Connel					

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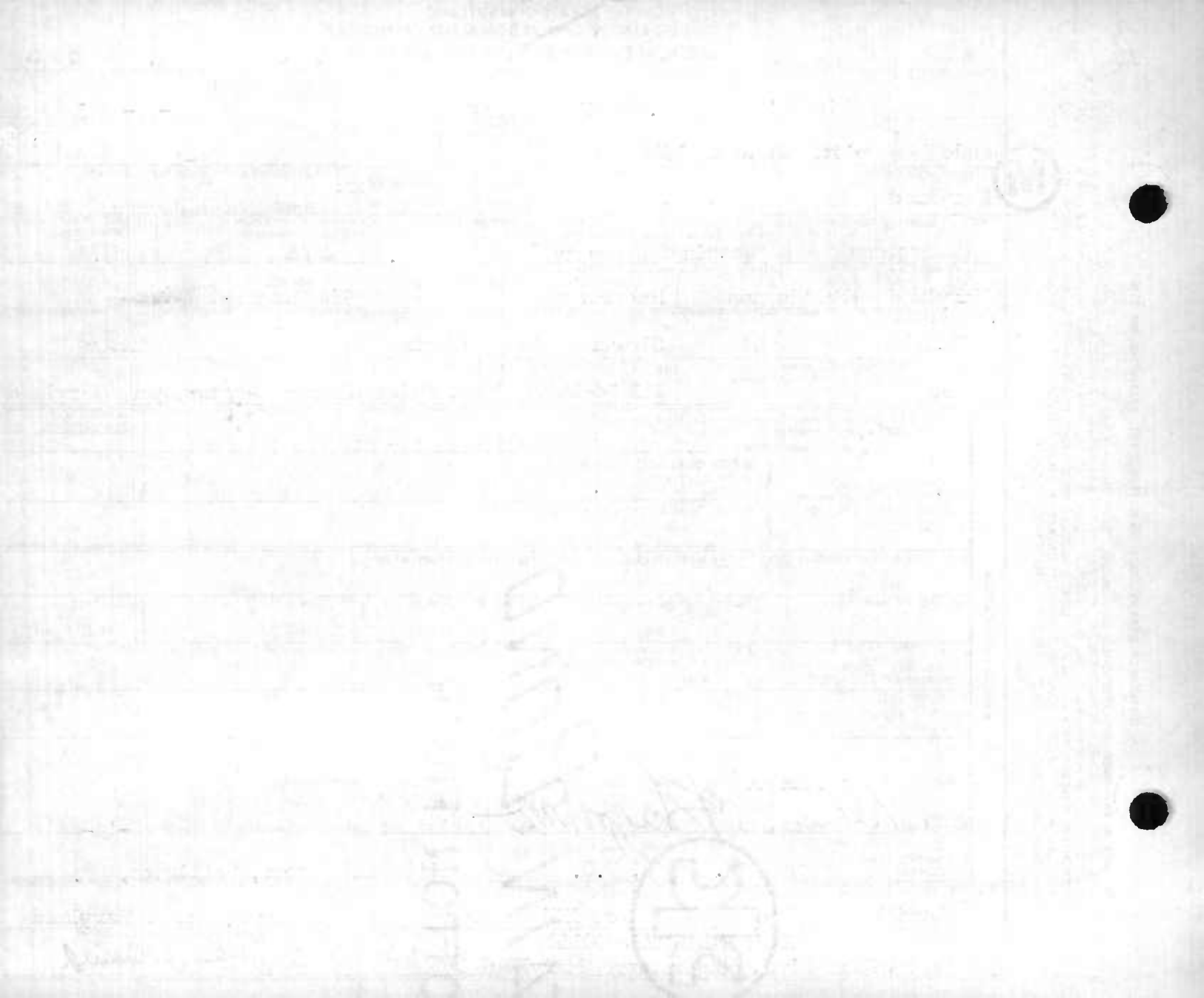
BRAND

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										3	REG. NO. 1	4	3	8	6
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Michael Anthony Sharer										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5-13-1983		7b. HOUR M A			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 4, 1965		6. AGE (IN YEARS LAST BIRTHDAY) 17 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD 5-13-1983		2d. HOUR 5:20 P M			
7a. PLACE OF BIRTH (STATE OR COUNTY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD					
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A					
13a. STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 928 Kenwood Drive 21740					
14. FATHER'S NAME FIRST MIDDLE LAST Donald Sharer						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gloria Ritter									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-84-3067		17. INFORMANT ADDRESS Mrs. Helen Sharer, Hagerstown, Maryland									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Dennis F. Smyth				TITLE (SPECIFY) Assistant MEDICAL EXAMINER						DATE SIGNED: 5-14-83					
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS: 111 Penn Street, Baltimore, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial				23b. DATE May 18, 1983		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland					
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME						25a. DATE REC'D. BY REGISTRAR MAY 19 1983		25b. REGISTRAR'S SIGNATURE John J. Conner							
415 East Wilson Blvd., Hagerstown, Maryland 21740															

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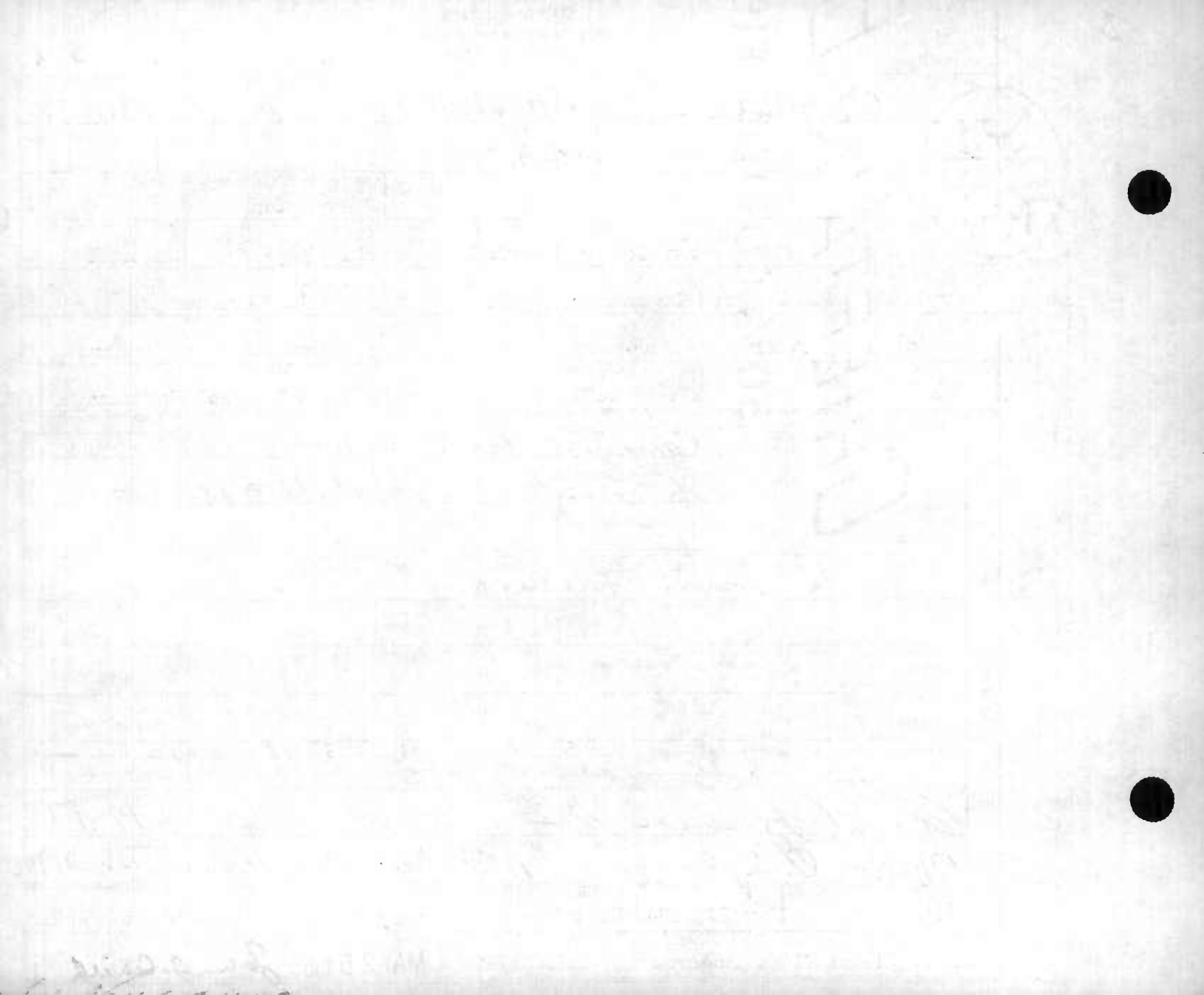
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the health officer within 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or coroner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 14387			
1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES L. SHEPPARD</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>May 18, 1983</b>			
3 SEX <b>Male</b>		4 RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 9, 1896</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>87</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>shipping</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>aircraft</b>	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Washington</b> 13c. CITY OR TOWN <b>Hagerstown</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>David Poter Sheppard</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elizabeth Souders</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-09-0678</b>		17. INFORMANT ADDRESS <b>Karen Angle Rt 4 Box 361 Hagerstown, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4140 Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>year</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Acute renal failure.</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>5-7</b> , 19 <b>82</b> , to <b>5-18</b> , 19 <b>83</b> , that (I) <del>was</del> lost saw the deceased alive on <b>5-18</b> , 19 <b>82</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> did not view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles D. Spencer</b>				22c. DATE SIGNED <b>5-19-83</b>		22d. ADDRESS <b>1198 Kenly Ave Hagerstown 21790</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>May 21, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown Washington Md.</b>	
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME 415 E. Wilson Blvd. Hagerstown, Md. 21740				25a. DATE REC'D. BY REGISTRAR <b>MAY 25 1983</b> REGISTRAR'S SIGNATURE <b>John J. Carver</b>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												3	REG. NO. 1 4 3 8 8								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Rosalind G Sherman</b>												2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>May 11 1983</b>		2b. HOUR ESTI. MATED <b>?</b>							
1. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11/ 21/ 1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>May 11 1983</b>		2d. HOUR <b>5:50 PM</b>							
7a. PLACE OF BIRTH (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington COUNTY MD.</b>									
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON COUNTY HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>									
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>WASHINGTON</b>		13c. CITY OR TOWN <b>HAGERSTOWN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>21740 1743 EDGEWOOD HILL CIRCLE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>IRVING BERKOWITZ</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ETTA LAUER</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>051-20-4112</b>				17. INFORMANT ADDRESS <b>MR. JOSEPH SHERMAN 1743 EDGEWOOD HILL CIRCLE HAGERSTOWN, MD 21740</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>9505 IMMEDIATE CAUSE (a) F-950 Drug Overdose</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Est. Several Hours</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. May 11 1983</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Self Administered Drug Overdose</b>													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1743 Edgewood Hill Cir. Hager. Wash. Md</b>													
22a. I certify that I take charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <b>Edward W. Ditto III</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER				DATE SIGNED <b>May 11, 1983</b>									
EXAMINER'S NAME (TYPE OR PRINT) <b>Edward W. Ditto III MD</b>				ADDRESS <b>217 W. Wash. St. Hagerstown, MD</b>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>5/13/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BNAI ABRAHAM CEM</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>HAGERSTOWN WASHINGTON MARYLAND</b>											
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 16 1983</b>				REGISTRAR'S SIGNATURE <b>John J. Carish</b>													
6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215																					





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 4 3 8 9  
REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Ethel G. Shively</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>May 11 '83</i>			2b. HOUR <i>10:10 A.M.</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>June 14, 1886</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>96</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington County</i> MD			
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Smithsburg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>Box 120</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Benjamin F. Welty</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Cora Martin</i>				16. ADDRESS <i>Waynesboro, Pa. 1726</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i>				16b. SOCIAL SECURITY NO. <i>213-74-2033</i>		17. INFORMANT <i>Mrs. Virginia Rickett</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Heart Failure</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>	
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) <i>Acute Myocardial Infarction</i> <i>3 weeks</i>	
		(c) <i>Chronic Coronary Vessel Disease</i> <i>20 years</i>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: *Cerebrovascular Accident with Right Sided Hemiplegia*

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>1759 Potomac Ave. Hagerstown</i>			
22a. I certify that (my) (this hospital) attended the deceased from <i>April 28</i> 19 <i>83</i> to <i>May 11</i> 19 <i>83</i> that (we) last saw the deceased alive on <i>May 11</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Robert Brull</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>5/11/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert Brull</i>				22e. ADDRESS <i>1759 Potomac Ave. Hagerstown</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>May 14, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Waynesboro Franklin Penna.</i>	
24. FUNERAL DIRECTOR NAME <i>David K. Cox</i>				50 S. Broad St. Waynesboro, Penna.		25a. DATE REC'D. BY REGISTRAR <i>MAY 16 1983</i>	
				25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For return to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 showing injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove certificates, Pages 1 and 2, and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 3 1 4 3 9 0		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST HELEN		MIDDLE J.		LAST SILVIOUS		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (IF WORK FOR MOST RECENT WORKING FIRM)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No		220-10-0335		Carroll T. Silvious, Cumberland, Md. (Husband)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u>										1 1/2 hrs.	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ventricular Fibrillation</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Brain Stem infarction, Diabetes Mellitus</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 1</u> 19 <u>83</u> , to <u>May 22</u> 19 <u>83</u> , that (1) <input checked="" type="checkbox"/> I saw the deceased alive on <u>May 22</u> 19 <u>83</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (2) <input type="checkbox"/> I did not view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
FE U. Porciuncula		WESTERN MARYLAND CENTER, HAGERSTOWN, MARYLAND 21740									
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		5-25-83		Forest Glen Cemetery		Greensprings Hampshire W. Va.					
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
James F. Scarpelli, Cumberland, Md.				MAY 25 1983		John J. Lauer					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH83 14391  
REG. NO.

1. FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
DONALD H. SMITH

2a. DATE OF DEATH MONTH DAY YEAR  
5-13-83

2b. HOUR  
3:17 AM

3. SEX  
M

4. RACE  
W

5. DATE OF BIRTH MONTH DAY YEAR  
11 12 12

6. AGE (IN YEARS LAST BIRTHDAY)  
70 YRS.

7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
Maryland

7b. CITIZEN OF WHAT COUNTRY?  
United States

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
Washington County MD

10. CITY OR TOWN OF DEATH  
Hagerstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
Washington County Hosp

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
retired

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE  
Maryland

13b. COUNTY  
Washington

13c. CITY OR TOWN  
Hagerstown

13d. INSIDE CITY LIMITS?  
YES ☐ NO ☒

13e. STREET ADDRESS  
2408 Marsh Pike 21740

14. FATHER'S NAME FIRST MIDDLE LAST  
George Sellers Smith

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
Lucy Hossington

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  
no

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)  
221-07-0772

17. INFORMANT ADDRESS  
Louise Smith Same as #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) 4275 Cardiac arrest  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)  
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?  
YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) lost  
saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE  
[Signature] DEGREE  
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED  
5/13/83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
ABDUL WATKINS MD

22e. ADDRESS  
1600 OAK HILL AVE. HAGERSTOWN, MD 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
Burial

23b. DATE  
5-16-83

23c. NAME OF CEMETERY OR CREMATORY  
Head of Christiana Newark New Castle Del.

23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME  
Gerald N. Minnich Hagerstown, Maryland

25a. DATE REC'D. BY REGISTRAR  
MAY 19 1983

25b. REGISTRAR'S SIGNATURE  
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained by the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 14392			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST Katherine Louise Smith				May 14, 1983 M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 02 14 1997		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) mail clerk		12b. KIND OF BUSINESS OR INDUSTRY publishing Co.	
13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1401 Virginia Avenue 21740	
14. FATHER'S NAME FIRST MIDDLE LAST William C. Koons				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 219-20-1250		17. INFORMANT ADDRESS Mrs. Elizabeth Boyd, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) a/cvd DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from May 1 19 83 to May 14 19 83, that (I) (we) lost (saw the deceased alive on) May 13 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE L. W. WILSON M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/14/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. W. WILSON H.O.				22e. ADDRESS 1385 Antietam St. Hagerstown Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE May 17, 1983		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION CITY OR TOWN COUNTY Boonsboro, Wash., Md.	
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland				25a. DATE REC'D. BY REGISTRAR MAY 20 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

BP

TP #



Handwritten text, possibly a signature or name, written in a cursive style.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4 '82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO. 4393	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
Marvin Howard Smith		MATED 5-10 1983	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
Male	White	9-13-1919	63 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
Virginia		U.S.A.	
8. CITY OR TOWN OF DEATH		9. BALTIMORE CITY OR COUNTY OF DEATH	
Hagerstown		Washington County	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Washington County Hospital		Driver	
13a. STATE		13b. CITY OR TOWN	
Maryland		Hagerstown	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
Joseph Howard Smith		Edna Long	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Yes		213-18-8749	
17. INFORMANT		ADDRESS	
Debbie Baeche		237 E. Irvin Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Ethanolism</u> 3030 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dennis F. Smyth, M.D.</u>		TITLE (SPECIFY) <u>M.D. Assistant</u>	
EXAMINER'S NAME (TYPE OR PRINT) <u>Dennis F. Smyth, M.D.</u>		DATE SIGNED <u>5-14-83</u>	
ADDRESS <u>111 Penn Street, Baltimore, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		5-17-83	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cedar Lawn Mem. Pk.		Hagerstown Wash. Maryland	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Gerald N. Minnich		MAY 19 1983	
Hagerstown, Maryland		25b. REGISTRAR'S SIGNATURE <u>John J. [Signature]</u>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) VANCE Allen SNOOK						2a. DATE KNOWN OF DEATH 5 25 1983		2b. HOUR 12:15	
3. SEX Male	4. RACE White	5. DATE OF BIRTH April 6, 1953	6. AGE (IN YEARS) 30 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 5 25 1983	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lineman		12b. KIND OF BUSINESS OR INDUSTRY Electrical	
10. CITY OR TOWN OF DEATH Hagerstown		13a. STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown	
14. FATHER'S NAME Roger		15. MOTHER'S MAIDEN NAME Jean L. Eyler		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 101 Patrick Rd. 21740			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-58-3993		17. INFORMANT ADDRESS Judy Sagel Snook Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 5-25- 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject came in contact with live wire.					
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) alley		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 200 blk. E. Washington St., Washington, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Ann M. Dixon, M.D.		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 5-26-83			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 28, 1983		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Md.			
24. FUNERAL DIRECTOR Rest Haven Funeral Chapel, Inc. 1601 Pennsylvania Ave. Hagerstown, Md.				25a. DATE REC'D. BY REGISTRAR JUN 1 1983		25b. REGISTRAR'S SIGNATURE John J. Gaudin			

10-1-58

(101)

TO: SAC, NEW YORK  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]  
RE: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR <b>Charles Leroy STOTTLEMYER</b>									
1 DECEASED NAME (TYPE OR PRINT) <b>Stottlemeyer Charles L</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>5 9 83</b>			2b. HOUR <b>5:45 P</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 30, 1916</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>67</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mt. Lena, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE WORK OR MOST PRODUCTIVE) <b>Metal Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Mfg.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Boonsboro</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rfd. 2 Box 278</b> 21713	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Charles Irving Stottlemeyer</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anne Rebecca Houpt</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-09-9031</b>		17 INFORMANT ADDRESS <b>Mrs. Catherine V. Stottlemeyer, Boonsboro, Md.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> 1629									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 mos</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									(b) DUE TO, OR AS A CONSEQUENCE OF
									(c) DUE TO, OR AS A CONSEQUENCE OF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Anterior lobe part of brain, Atrod. F. infection</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/15/83</b> to <b>5/19/83</b> , that (I) (we) last saw the deceased alive on <b>5/15/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <del>not</del> view the body after death.									
22b. SIGNATURE <b>Edison B. Moody</b> DEGREE						22c. DATE SIGNED <b>5/18/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edison B. Moody, M.D.</b>						22e. ADDRESS <b>St. James Rd., Hagerstown, Md. 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-12-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lena Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Mt. Lena, Wash. Co., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>John H. Bast, Jr.</b> ADDRESS <b>Boonsboro, Md. 21713</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 16 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Casper</b>			







Charles Ledy

STATION

Mrs

Miss

March 30, 1915

07

Washington

Mr. Ledy, Mr. Ledy, Mr. Ledy

Highway, Washington County, Hospital, Hotel, other, etc.

Highway, Washington County, Hospital, Hotel, other, etc.

Charles Irving Scott, Mrs. Catherine W. Scott, etc.

Highway, Washington County, Hospital, Hotel, other, etc.

Highway, Washington County, Hospital, Hotel, other, etc.

Highway, Washington County, Hospital, Hotel, other, etc.

Highway, Washington County, Hospital, Hotel, other, etc.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 4 3 9 6

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN ASHBY TEMPLON</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>MAY 8 1983</b>			2b. HOUR <b>2:04 P.M.</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 8, 1946</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>36</b> YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>MAY 8 1983</b>			2d. HOUR <b>2:04 P.M.</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b> MD.		
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Welder</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Metal</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Shinham Rd. 21740</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Matthew Elvin Templon</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Thelma Mae Printz</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>219-52-1644</b>		17. INFORMANT <b>Thelma Templon</b>			ADDRESS <b>436 Carlton Ave Hagerstown, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>N-854 - SELF INFLICTED GUNSHOT WOUND TO HEAD</b> <b>9554</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MOMENTS</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>1:05 P.M. MAY 8 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>SELF-INFLICTED GUNSHOT WOUND TO HEAD</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>HOME</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>ROUTE #4, Box 382, HAGERSTOWN, WASHINGTON, MD.</b>			
22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Edward W. Ditto, III</b>			TITLE (SPECIFY) <b>DEPUTY</b>			DATE SIGNED <b>MAY 9, 1983</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>EDWARD W. DITTO, III, M.D.</b>			ADDRESS <b>HAGERSTOWN, MARYLAND 21740</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>May 11, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery Hagerstown Wash. Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR <b>Rest Haven Funeral Chapel</b>				25a. DATE RECD. BY REGISTRAR <b>MAY 16 1983</b>				
25b. REGISTRAR'S SIGNATURE <b>John J. Canfield</b>								

24. FUNERAL DIRECTOR

Rest Haven Funeral Chapel

1601 Pennsylvania Ave. Hagerstown, Md.

25a. DATE RECD. BY REGISTRAR

MAY 16 1983

25b. REGISTRAR'S SIGNATURE

John J. Canfield

Tenn. 1992.

THEY ARE THE ONLY

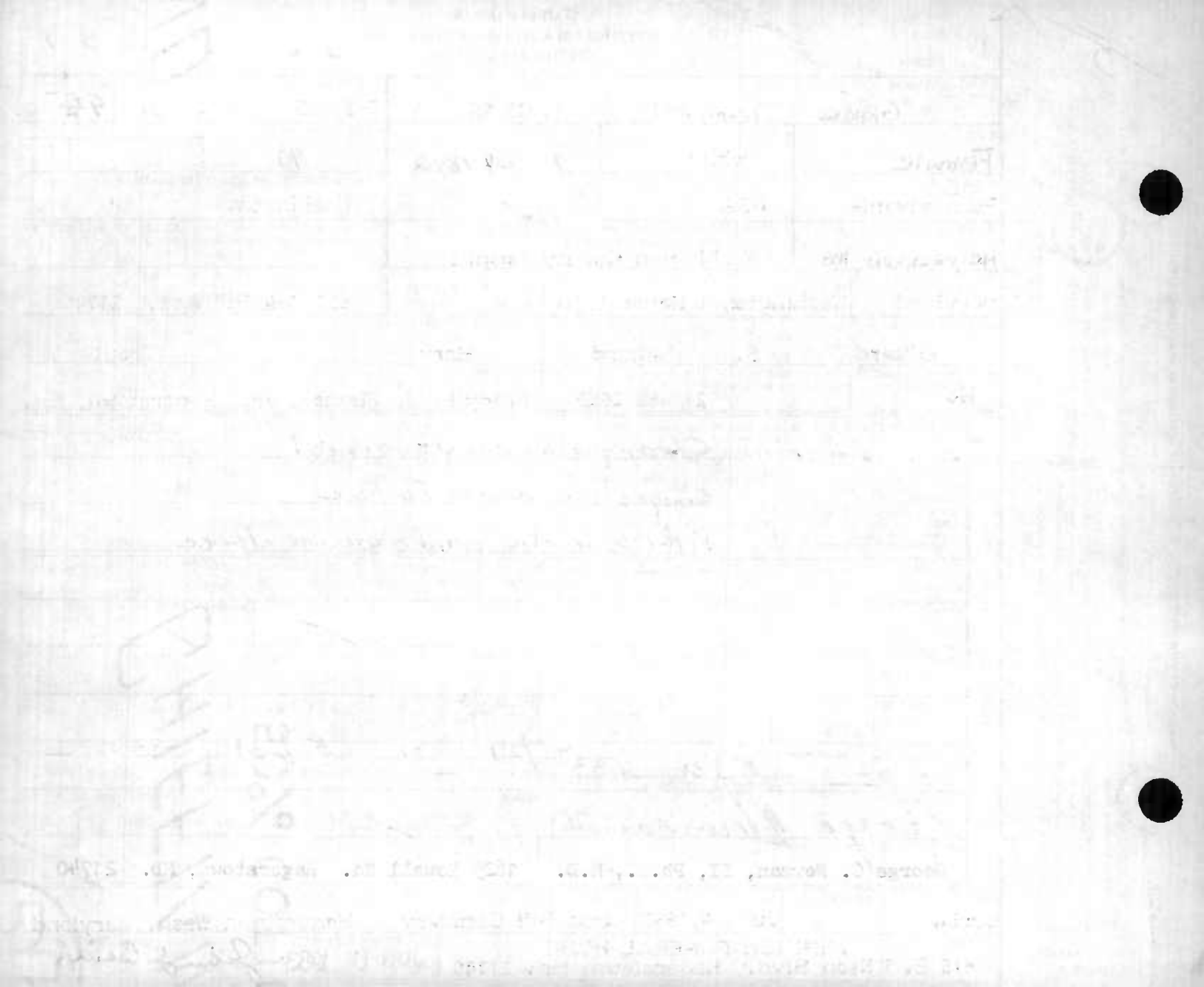
... III ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 3 1 4 3 9 7		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <u>Grace Howard THOMAS</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>5-31-83</u>		2b. HOUR <u>9:45</u> M			
3. SEX <u>Female</u>		4. RACE <u>white</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>7 28 1892</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>90</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington</u> MD.			
10. CITY OR TOWN OF DEATH <u>Hagerstown, Md.</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington County Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Washington</u>		13c. CITY OR TOWN <u>Hagerstown</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>831 Oak Hill Ave. 21740</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Edward S. Howard</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mary Trout</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>				16b. SOCIAL SECURITY NO. <u>214-48-2659</u>		17. INFORMANT ADDRESS <u>Franklin M. Thomas, Jr., Hagerstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>no</u>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/27</u> 19 <u>81</u> to <u>5/31</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>5/31</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>George Newman II</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>George C. Newman, II, Ph.D., M.D.</u>				22e. ADDRESS <u>1825 Howell Rd. Hagerstown, MD. 21740</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		23b. DATE <u>June 4, 1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Hagerstown, Wash., Maryland</u>			
24. FUNERAL DIRECTOR NAME <u>MINNICH FUNERAL HOME</u>				24b. ADDRESS <u>415 E. Wilson Blvd., Hagerstown, Md. 21740</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 6 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) <b>Levin Edward TRITAPOE</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>May 6, 1983</b>			2b. HOUR <b>2:00 P</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 9, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Knoxville, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.			
10. CITY OR TOWN OF DEATH <b>Knoxville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rfd. 2 Box 60</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Car Inspector</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Knoxville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rfd. 2 Box 60 21758</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Calvin Tritapoe</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hattie B. Snyder</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>705-10-3036</b>		17. INFORMANT ADDRESS <b>Mrs. Minnie V. Tritapoe, Knoxville, Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 mi</b> 4100 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Coronary Occlusion</b> <b>5 mi</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Old M.D. Arteriosclerosis</b> <b>54 yrs</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Arteriosclerosis A. V. disease</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>June 1962</b> to <b>May 6 1983</b> , that (I) (we) lost saw the deceased alive on <b>May 6 1983</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>AT Bricc</b> DEGREE <b>MD</b>				22c. DATE SIGNED <b>5/8/83</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>AT Bricc</b>				22e. ADDRESS <b>Loperson Mt 21755</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal- Burial</b>		23b. DATE <b>5-9-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lovettsville, Loudan Co., Va.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>John H. Bast, Jr. Boonsboro, Md. 21713</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 11 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Gough</b>			

BP



John H. Davis	John H. Davis	John H. Davis	John H. Davis	John H. Davis
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20% COLTON



John H. Davis, Union Cemetery, Knoxville, Tenn.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item #6 FilmG580 6/23/83 rc										
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) <b>OWEN EARLY TUELL</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 7 1983</b>		2b. HOUR <b>2:45 P.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 16, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON County MD.</b>				
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SERVICE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GARAGE</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD.</b>					13b. COUNTY <b>WASH.</b>		13c. CITY OR TOWN <b>HAGERSTOWN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM TAYLOR TUELL</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FLORENCE EMMA "SHIFFLET"</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>- No -</b>					16b. SOCIAL SECURITY NO. <b>223-18-9977</b>		17. INFORMANT ADDRESS <b>WILLIAM T. TUELL / 17 N. MULBERRY ST.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF RECTUM</b> <b>1541</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>JAN 1981</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>										
19a. DATE OF OPERATION <b>MAY 7 1983</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RECURRENT CARCINOMA RECTUM</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>NONE</b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 5</b> , 19 <b>83</b> , to <b>MAY 7</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>5/7/83</b> , 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Francisco G. Japzon MD</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>5/8/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FRANCISCO G. JAPZON MD</b>					22e. ADDRESS <b>645 E. FIRST ST HAGERSTOWN, MD 21740</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>5/9/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SMITHSBURG CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>HAGERSTOWN, WASH. MD.</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>REST HAVEN FUNERAL CHAPEL, INC. 1601 PENNA. AVE. HAGERSTOWN, MD.</b>					25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE <b>MAY 12 1983</b>					



CHART 1000

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MAY 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use at the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

BP

DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		8314400						REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARY MILDRED VANRYSWICK</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>5/11/83</b>		2b. HOUR <b>4<sup>9</sup></b> M	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 5, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>77</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Washington MD.</b>			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WESTERN MARYLAND CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>						13b. COUNTY <b>St. Mary's</b>		13c. CITY OR TOWN <b>Leonardtown</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>John Mills</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jane Elizabeth Farr</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. #1, Box 108-A 20650</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-22-1751A</b>		17 INFORMANT ADDRESS <b>Joseph H. Raley, Baltimore, Maryland 21230</b>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>5789 IMMEDIATE CAUSE (a) Hemorrhagic Shock.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Week</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Secondary to G.I. Bleeding</b>								<b>Week</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Respiratory Failure 1981-82</b>								<b>Years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (X) (this hospital) attended the deceased from <b>1/8/82</b> 19__ to <b>5/11/83</b> 19__, that (I) <del>XX</del> lost saw the deceased alive on <b>5/11/83</b> 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. <del>XXX</del>									
22b. SIGNATURE <b>MICANINIA M.D.</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>5/11/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICANINIA M.D.</b>				22e. ADDRESS <b>1500 Pennel Lane HAGERSTOWN, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-13-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Our Lady's</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Leonardtown, St. Mary's, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Brinsfield Funeral Home, Leonardtown, Maryland</b>				25a. DATE REC'D. BY REGISTRAR MAY 18 1983					
				25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>					

MEDICAL CERTIFICATION



MAY 18 1953  
J. S. G. G. G.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 4 4 0 1  
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Samuel A. Wagaman</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>5 11 83</i>		2b. HOUR <i>5:10</i> M.	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>June 14, 1914</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>68</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Penna.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington Co.</i> MD.	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Truck driver</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Oil Co.</i>	
13a. USUAL RESIDENCE (IF NOT IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles D. Wagaman</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bertha May Rock</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>Yes WW #II</i>		16b. SOCIAL SECURITY NO. <i>173-03-3088</i>	
17. INFORMANT <i>Mrs. Louise H. Wagaman</i>		18. ADDRESS <i>Hagerstown, Md. 21740</i>		19. STREET ADDRESS <i>1645 Evelyn Ave.</i>		20. CITY OR TOWN <i>Hagerstown</i>	

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4100 Acute Myocardial Infarction</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>11 hrs</i>	
IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Intense &amp; Chronic Cardiovascular Disease</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  
*Adult Respiratory Distress Syndrome & Pulmonary*

19a. DATE OF OPERATION <i>4/20/83</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>removal of gangrene left leg</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
21e. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		21h. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from <i>4/19/83</i> to <i>5/4/83</i> , that (I) (we) last saw the deceased alive on <i>5/11/83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>C. C. Su MD</i>		22c. DEGREE <i>MD</i>		22d. DATE SIGNED	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>C. C. Su MD</i>		22f. ADDRESS <i>201 S. Cleveland Ave. Hagerstown Md</i>		22g. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22h. DATE SIGNED	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5/14/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Waynesboro Franklin Penna.</i>	
24. FUNERAL DIRECTOR <i>David Lane</i>		ADDRESS <i>50 S. Broad St.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 16 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John E. ...</i>	

*[Faint, illegible handwritten text on lined paper]*

10/1/70



BP

DHMH-16 50M 1/B1  
(VRA 15, 4)

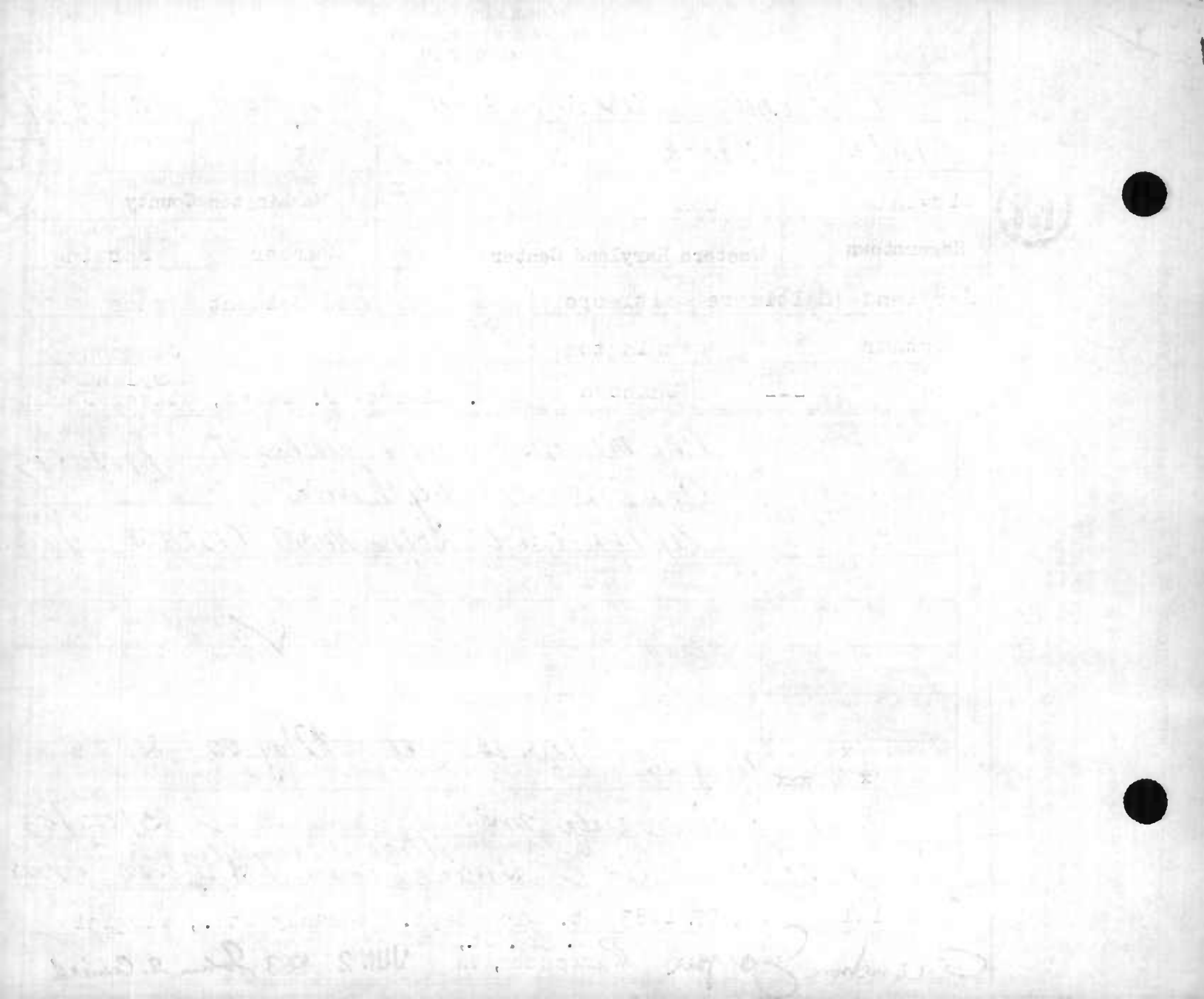
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8314402 REG. NO.											
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) <b>CLAUDE WASHINGTON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 22 1983</b>				2b. HOUR MIN. <b>9:40</b>			
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 15 1978</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>105</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.					
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b>				MD.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Western Maryland Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>							
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>21216 3018 Belmont Avenue</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur Washington</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ada Johnson</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Unknown</b>		17. INFORMANT ADDRESS <b>Mrs. Alberta F. Dawes, Silver Spring Maryland</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARDIAC Arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIO SCLEROTIC HEART DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>Many years.</b>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)															
9a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (X) (this hospital) attended the deceased from <b>April 14 1981</b> to <b>May 22 1983</b> , that (X) (we) last saw the deceased alive on <b>May 22 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (X) (did) (did not) view the body after death.															
22b. SIGNATURE <b>FE U. Porciuncula</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>5/23/83</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FE U. Porciuncula</b>				22e. ADDRESS <b>1500 Pennsylvania Ave. HAGERSTOWN, MARYLAND 21740</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>May 27, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Bapt.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brandy Sta., Virginia</b>									
24. FUNERAL DIRECTOR NAME <b>G. Washington Jayne</b>				ADDRESS <b>35 N. 3rd. St. Warrenton, VA</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 2 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canfield</b>							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. FOR STATE REGISTRAR		83 14403 REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR MIN.	
THOMAS		WILBUR		WEAVER		5-18-83			9:15 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		2-10-1924		59 YRS.						
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Penna.		U.S.A.				Washington MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown		Washington Co. Hospital						Laborer		State Road Dept.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS				
Maryland		Washington		Big Pool				Box 60 21711				
14. FATHER'S NAME (TYPE OR PRINT)		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
Wilbur		B. Weaver		Esther May Nicholson								
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		18b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
Yes		1948-1954		183-12-2394		Elsie V. Weaver		Same as 13.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4960 DUE TO, OR AS A CONSEQUENCE OF: (b) DUE TO, OR AS A CONSEQUENCE OF: (c) Giant Aneurysm (Heart) Med. Certificate Policy Bismil												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) June 1948 - Int. Cervical Bleeding												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 5-16-83, to 5-18-83, that (I) (we) last saw the deceased alive on 5-18-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.		22b. SIGNATURE (TYPE OR PRINT)		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-14-83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
E. R. Rodriguez		384 John Cleveland, Hagerstown MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial		5-20-1983		Parkhead Cemetery		Big Pool Washington Md.						
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Richard J. Shaw		Hagerstown MD		MAY 31 1983		John J. Cahill						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar, 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. 83 14404			
1 - STATE REGISTRAR <b>Raymond Ellsworth Welch Sr.</b> <b>CERTIFICATE OF DEATH</b>			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Raymond E. Welch Sr.</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>05-16-83</b> 2b. HOUR <b>7:45 AM</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>06 09 22</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.		10. USUAL OCCUPATION (TYPE OF WORK OR LAST SIGNIFICANT LIFE) <b>Superior Fairchild</b>	
11. CITY OR TOWN OF DEATH <b>Hagerstown</b>		12. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE <b>MD</b>	13b. COUNTY <b>Wash</b>	13c. CITY OR TOWN <b>City</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Welch</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elizabeth Williams</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>215-18-1266</b>	
17. INFORMANT <b>Hazel L. Welch</b>		17. ADDRESS <b>Route # 3 Box 317-B Hagerstown, Md. 21740</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5860</b> IMMEDIATE CAUSE (a) <b>Tachyarrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Renal Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Hx</b> <b>Yrs</b> <b>Yrs</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4/9 19 83</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. DATE SIGNED <b>5/16/83</b>	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4/9 19 83</b> to <b>5/16 19 83</b> that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>5/16 19 83</b> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.			
22a. SIGNATURE <b>Myung S. Kim</b>		22b. ADDRESS <b>1500 Penna. Ave Hagerstown Md. 21740</b>	
22c. DATE SIGNED <b>5/16/83</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MYUNG S. KIM</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-20-83</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Memorial Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Washington, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc., Hagerstown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 24 1983</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>			

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RAYMOND ELLIOTT WALSH

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House # 3, Box 314-B  
Hagerstown, Md. 21740

Harold I. Walsh

218-18-1300

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Initial 2-20-63 Cedar Lawn Memorial W. Hagerstown, Washington, Md.

A. S. Collins Funeral Home, Inc., Hagerstown, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8314405 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Russell Alexander WOLFINGER					2a. DATE OF DEATH MONTH DAY YEAR May 1, 1983			2b. HOUR 2 P M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Sept 5, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt 8				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farn	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Wash. 13c. CITY OR TOWN Hagerstown					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt 8 Box 91 21740		
14. FATHER'S NAME FIRST MIDDLE LAST Clarence S. Wolfinger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Luella M. Shifler					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-34-0934		17. INFORMANT ADDRESS Mrs. Ethel I. Wolfinger Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple myeloma</u> 2030 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>4/27</u> 19 <u>83</u> , to <u>5/1</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>4/27</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Frederic H. Kass, III, M.D.</u>				DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/2/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederic H. Kass, III, M.D.				22e. ADDRESS 1825 Howell Rd. Hagerstown, MD 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 4, 1983		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash, Md.			
24. FUNERAL HOME Davis Funeral Home P.A. Smithsburg, Md.				25a. DATE REC'D. BY REGISTRAR MAY 6 1983					
25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs at home, the physician must be called to the home. If the death occurs in a hospital, the physician must be called to the hospital. If the death occurs in a nursing home, the physician must be called to the nursing home. If the death occurs in a prison, the physician must be called to the prison. If the death occurs in a mental hospital, the physician must be called to the mental hospital. If the death occurs in a hospital, the physician must be called to the hospital. If the death occurs in a nursing home, the physician must be called to the nursing home. If the death occurs in a prison, the physician must be called to the prison. If the death occurs in a mental hospital, the physician must be called to the mental hospital.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to the scene of death.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		83 REG. NO. 14406							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Mary Rosalie Younker				2a. DATE OF DEATH MONTH DAY YEAR May 3, 1983		2b. HOUR 3:45 PM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 5, 1901		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hancock		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 281 West Main Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hancock		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 208 Jackson Street 21750	
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Elmer Sensel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose I. Shives					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220 26 5908		17. INFORMANT Dolores Y. Creek		ADDRESS 281 West Main Street Hancock, Maryland 21750			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: +140 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) ASHD DUE TO, OR AS A CONSEQUENCE OF (c) Congestive heart failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 20 years 2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (the hospital) attended the deceased from 11-27-61 to 4-13-83, that (I) (we) lost saw the deceased alive on 4-13-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE FB Thomas III M.D.				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 05-06-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank B Thomas, III, M.D.				22e. ADDRESS Two Tonoloway Hancock, Md. 21750					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/7/83		23c. NAME OF CEMETERY OR CREMATORY Stone Bridge		23d. LOCATION CITY OR TOWN COUNTY STATE Rt. 2 Hancock, Wash., Md. 21750			
24. FUNERAL DIRECTOR NAME Richard J. Shone Hancock MD.				25a. DATE REC'D. BY REGISTRAR MAY 12 1983		25b. REGISTRAR'S SIGNATURE John J. Lohr			

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Figure 2

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